Commonwealth of Virginia
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, VA 23219

June 20, 2008

Dear Prospective Vendor:

The Department of Medical Assistance Services (DMAS) is soliciting proposals from firms that meet the external quality review organization qualifications, as defined by federal regulations (§ 42 CFR Part 438.354, Subpart E) AND that have certification as a federally designated Quality Improvement Organization (QIO) formerly known as Peer Review Organization (PRO). The offering QIOs shall submit certification of their status. The selected Contractor will be responsible for evaluating the access, quality, appropriateness, timeliness, and satisfaction with services provided to the Medicaid and State Children's Health Insurance Program (SCHIP) recipients. Specific details about this procurement are in the enclosed Request for Proposals (RFP) 2008-05. Vendors must check the DMAS' web site at www.dmas.virginia.gov or check the eVA web site at http://www.eva.virginia.gov/ for any addendums or notices regarding this RFP.

Vendors who wish to submit a proposal are required to submit a Letter of Intent which must be received by the Department no later than 2:00 PM local time on July 10, 2008. The submission of a Letter of Intent is a prerequisite for submitting a proposal; proposals shall not be accepted from Vendors who have not submitted a Letter of Intent by the deadline specified above. Letters of Intent shall be sent to:

Department of Medical Assistance Services
Attention: William D. Sydnor
600 East Broad Street, Suite 1300
Richmond, VA 23219

The Commonwealth will not pay any costs that any Vendor incurs in preparing a proposal and reserves the right to reject any and all proposals received. Vendors are requested not to call this office. All issues and questions related to this RFP should be submitted in writing to the attention of Carol Stanley, Disease Management and Quality Improvement Analyst, Healthcare Services Division, 600 East Broad Street, Suite 1300, Richmond, VA 23219. In order to expedite the process of submitting inquiries, it is requested that each vendor submit all inquiries in one MS Word document attached to an e-mail to EQRO@dmas.virginia.gov. The inquiries should be very specific with regards to the question, and when feasible, include citation of the page number and RFP section numbers that correspond with the question.

Sincerely,

William D. Sydnor
William D. Sydnor
Contract Management Director

REQUEST FOR PROPOSALS
RFP 2008-05

Issue Date: June 20, 2008

Title: External Quality Review Services

Period of Contract: An initial period of three years from award of contract, with provisions for three twelve-month extensions.

All inquiries should be directed in writing via email in MS Word Format to:

Carol Stanley
Disease Management and Quality Improvement Analyst
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219
EQRO@dmas.virginia.gov

Deadline for submitting inquiries and Letter of Intent is 2:00 pm E.D.S.T., July 10, 2008. Proposal Due Date: Proposals will be accepted until 2:00 p.m. E.D.S.T. on August 13, 2008

Submission Method: The proposal(s) must be sealed in an envelope or box and addressed as follows:

"RFP 2008-05 Sealed Proposal"
Department of Medical Assistance Services
600 E. Broad Street, Suite 1300
Richmond, Virginia 23219
Attention: William Sydnor

Facsimile Transmission of the proposal is not acceptable.

Contractors who wish to submit a proposal are required to submit a Letter of Intent which must be received by the Department no later than 2:00 PM local time on July 10, 2008. The prior submission of a Letter of Intent is a prerequisite for submitting a proposal; proposals shall not be accepted from Contractors who have not submitted a Letter of Intent by the deadline specified above. Letters of Intent shall be sent to:

Department of Medical Assistance Services
Attention: William D. Sydnor
600 East Broad Street, Suite 1300
Richmond, VA 23219

Note: This public body does not discriminate against faith-based organizations in accordance with the Code of Virginia, §2.2-4343.1 or against an Offeror because of race, religion, color, sex, national origin, age, disability, or any other basis prohibited by State law relating to discrimination in employment.

In compliance with this Request for Proposal and to all conditions imposed therein and hereby incorporated by reference, the undersigned proposes and agrees to furnish the services contained in their proposal.

Firm Name (Print)	F.I. or S.S. Number
Address	Print Name
Address	Title
City, State, Zip Code	Signature (Signed in Ink)
Telephone	Date Signed
Fax Number	
eVA Registration Required	eVA Vendor #:

Check (√) Applicable Status:

Corporation ---------- Partnership --------- Proprietorship -------- Individual ------
Woman Owned ---------- Minority Owned ---------- Small Business ---------
If DMBE Certified, provide certification #: ----------

COMMONWEALTH OF VIRGINIA

DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

REQUEST FOR PROPOSALS

FOR

External Quality Review Services

RFP 2008-05

ISSUED June 20, 2008

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RFP 2008-05 External Quality Review

I. PURPOSE

The purpose of this Request for Proposal (RFP 2008-05) is to solicit proposals to establish a contract through competitive negotiations for the purchase of external quality review (hereinafter "EQR") services, by the Department of Medical Assistance Services (hereinafter the "Department" or "DMAS") of the Commonwealth of Virginia. The vendor must meet the external quality review organization qualifications, as defined by federal regulations (§ 42 CFR Part 438.354, Subpart E) AND that have certification as a federally designated Quality Improvement Organization (QIO) formerly known as Peer Review Organization (PRO). The offering QIOs shall submit certification of their status. The selected QIO (hereinafter "Contractor" or "EQRO"), will serve as the external quality review organization for the Title XIX Virginia Medical Assistance Program (hereinafter "Medicaid") and the Title XXI State Children's Health Insurance Program (hereinafter "SCHIP"). The Contractor will be responsible for evaluating the access, quality, appropriateness, timeliness, and satisfaction with services provided to Medicaid and SCHIP recipients in Virginia. The Contractual agreement with an EQRO will allow the Department to meet the Centers for Medicare & Medicaid Services' (hereinafter "CMS") requirements for EQR and to monitor and help improve the care received through Virginia's Medicaid and SCHIP programs. This RFP integrates the tasks for Medicaid EQR and the SCHIP EQR functions. All proposals submitted must be for the entire range of services identified in this contract.

Prospective Offerors must possess experience in: administering federally mandated EQR activities for Medicaid managed care; identifying disparities in healthcare services among underserved populations; leading quality improvement collaboratives; providing guidance and technical assistance for quality improvement to state agencies and managed care plans; conducting medical record reviews using abstraction tools; using efficient and effective methods for measuring MCO adherence to quality assurance standards; and using statistically valid sampling, analysis, synthesis, and reporting methodologies. Offerors must also possess experience in writing reports that are well organized, timely, clear, concise, and useful to policy and program planners.

II. BACKGROUND and DEFINITIONS

DMAS is the single state agency in the Commonwealth of Virginia that administers the Medicaid and FAMIS Plus programs, which are under Title XIX of the Social Security Act. FAMIS Plus is Virginia Medicaid's designation for its covered children. DMAS also administers the Virginia State Children's Health Insurance Program (hereinafter "SCHIP"), known as "Family Access to Medical Insurance Security (hereinafter "FAMIS")", under Title XXI of the Social Security Act for low-income people. These programs are financed by federal and state funds and administered by the state according to federal and state guidelines. Both programs include coverage of medical services for eligible Medicaid and FAMIS enrollees.

The Department provides Medicaid coverage to individuals primarily through two delivery systems: managed care and fee-for-service. The Department oversees the

development, implementation, and operation of the managed care and fee-for-service programs. The Department currently operates two Medicaid managed care programs: MEDALLION, a primary care case management program (hereinafter "PCCM") delivered through DMAS; and Medallion II, a program that delivers care through managed care organizations (hereinafter "MCO") under contract with the Department. In certain areas of the state, the Department contracts with only one MCO. In MCO areas, recipients have the choice of the MEDALLION PCCM or the Medallion II program. The mandatory managed care programs operate under a CMS 1915(b) Waiver and in accordance with the Code of Federal Regulations.

The MEDALLION program is a managed care, PCCM program. This program is administered in its entirety by the Department. In MEDALLION, a recipient's health care is managed by a primary care provider (hereinafter "PCP"). The PCP manages the recipient's health care and acts as a gatekeeper for specialty service referrals. There are some services that do not require a PCP referral. Examples of these services include but are not limited to emergency services, outpatient mental health services, substance abuse services, and community mental health rehabilitative services. In return the PCP is reimbursed $3 per recipient per month (hereinafter "PMPM"). Providers are reimbursed on a fee-for-service basis for all covered services rendered.

There are some individuals who are excluded from participating in MEDALLION, even if they reside in a MEDALLION region. These individuals are covered under the fee-for-service program. Examples of MEDALLION excluded individuals include, but are not limited to, children in foster care, individuals who reside in a state mental institution, individuals with Medicare coverage and individuals who are enrolled in home and community based waivers, and hospice.

The Medallion II program is a fully capitated, risk-based, mandatory Medicaid managed care program. In most areas of the Commonwealth, qualified Medicaid recipients choose between at least two contracted Managed Care Organizations (MCO). In areas where only one contracted MCO participates, recipients have the choice of the MEDALLION PCCM or the Medallion II program.

Under Medallion II, the contracted MCO receives a capitated PMPM payment that covers a comprehensive set of services, regardless of how much care is used by the recipient. The MCOs accept full financial risk for each recipient's health care. This monthly payment includes all covered contract services. There are some individuals who are excluded from participating in Medallion II, even if they reside in a Medallion II region. These individuals are covered under the fee-for-service program. Examples of Medallion II excluded individuals include, but are not limited to, children in foster care, individuals who reside in state mental institutions, and individuals who are enrolled in hospice. There are certain services that are "carved out" of the Medallion II contract and reimbursed through the Department's fee-for-service program. These services include, but are not limited to, community mental health rehabilitative services, certain substance abuse treatment services, environmental lead investigations, school health services, dental services, and nutritional supplements for children under age 21.

FAMIS was created in 2001 to ensure that a greater number of children could gain access to health insurance. FAMIS covers eligible children (who are not eligible for Medicaid, are not covered under health insurance, and are not members of a family eligible for coverage under the state employee health plan) from birth through age 18 in families with a gross income at or below 200% of the Federal Poverty Level.

FAMIS provides a comprehensive benefits package that includes well child care and preventive services. Although FAMIS has cost sharing, FAMIS enrollees who are in a managed care organization will have nominal co-payments. Cost sharing will not exceed 5% of a family's gross income for families with incomes from 150% to 200% of poverty, and is not required for well-child and preventive services. Cost sharing will not exceed 2.5% of gross income for families with incomes below 150% of poverty. Some children who live in areas where MCOs are not available access their care through FAMIS FFS. There is no cost sharing for clients in FAMIS FFS. FFS benefits are like Medicaid FFS benefits.

Children enrolled in FAMIS, are enrolled in MCOs, if available in their locality. As of February 2008, 411,956 Medicaid and 44,468 FAMIS' enrollees were being served by five (5) MCOs in 114 localities (see Attachment A-Managed Care Coverage Map and MCO Characteristics).

In addition, the Virginia Medicaid program also provides coverage for services not otherwise covered for the general Medicaid population through other types of CMS' waiver programs. Each CMS Waiver has an established set of eligibility and financial criteria as well as a unique set of benefits available to qualifying individuals. Certain Home and Community Based waivers (hereinafter "HCB") operate under a 1915(c) Waiver, and allow Medicaid to cover in home and community based support services, including, but not limited to, personal care, home modifications, assistive technology, and certain other supportive services for Medicaid individuals who are at risk for institutionalization. Some HCB waiver programs available to enrollees include the Elderly and Disabled with Consumer Direction (EDCD), Technology Assisted, Mental Retardation Waiver, etc. Information about these waiver programs is available on the DMAS' website at http://www.dmas.virginia.gov/ltc-home.htm.

Some waiver services are available either through a traditional agency or through "consumer direction." Agency-directed services are controlled by an agency that hires staff and assigns them to the individual who needs services. Consumer-directed services are controlled by the person with a disability or by someone acting on his or her behalf. The consumer recruits, hires, supervises, and fires (if need be) his or her own staff. The consumer is the employer of his or her staff and signs off on the timesheets for payment, which are then submitted to a fiscal agent for payment. A person using consumer-directed services will have a facilitator, a covered service under the HCB waiver, for assistance in learning about consumer-directed services and for ongoing support.

Virginia Acute and Long-Term Care Integration (hereinafter "VALTC") is an initiative designed to improve the quality of life of Virginia's Medicaid-enrolled seniors and individuals with disabilities. This new managed care system strives to empower qualifying individuals to remain independent and reside in the setting of their choice for as long as possible through the provision of a streamlined primary, acute, and long-term care service delivery system. VALTC offers ongoing access to quality health and long-term care services, care coordination, and referrals to appropriate community resources. Information about the Integration of Long Term Care, including the pilot localities is available on the DMAS' website at http://www.dmas.virginia.gov/altc-home.htm.

Currently, individuals who are dually eligible for Medicare and Medicaid, and individuals who participate in the Elderly or Disabled with Consumer Direction (hereinafter "EDCD") waiver are excluded from participating in managed care. These individuals, who are often very frail, currently receive very little assistance with the coordination of their services – and their services are often very complex.

Through VALTC, adult individuals 21 and over who are dually eligible (have Medicaid and Medicare coverage) and/or who are EDCD waiver participants (in certain areas of the Commonwealth) will be able to receive their health care and long-term care services through a coordinated delivery system. (Initially children under age 21 will not be covered under the VALTC program.) These individuals will be enrolled in a new MCO program that will offer ongoing access to quality health and long-term care services, coordinated benefits between Medicare and Medicaid, care coordination, and referrals to appropriate community resources.

The initial pilot of this new program is slated to begin February 2009 in the Tidewater area for approximately 15,000 dual eligible and EDCD waiver participants and in December 2009 in the Richmond area for approximately 11,000 dual eligible and EDCD waiver participants. This program entails integrating managed care, long-term care, and Medicare when possible, to offer our elderly and disabled participants better coordination and intervention to lead to better health outcomes.

DMAS also provides oversight for the Program of All-inclusive Care for the Elderly (hereinafter "PACE"), a model that organizes a range of services from health care to social support, and blends funding streams to pay for them. The focal point for delivering these services is an adult day care center. Currently, Virginia has six (6) PACE sites, which are in the process of ensuring their operational processes are in compliance with CMS' quality assurance requirements. In order to assist the PACE sites with providing services that are timely, accessible, and quality driven, the EQRO will assess the extent of each PACE sites' compliance with federal requirements.

Dental services are a mandatory Medicaid benefit for children. Section 1902(a)(43) of the Social Security Act specifically requires that state Medicaid plans provide or arrange for such services. In addition, the Virginia State Plan for FAMIS, as provided for in the

Code of Virginia § 32.1-320, as amended, includes provisions for dental benefit coverage for FAMIS' children.

There is one Dental Benefits Administrator (hereinafter "DBA") for Virginia's Medicaid/FAMIS dental program, *Smiles for Children* (hereinafter "SFC"). A biannual operational systems review will be conducted by the Contractor in order to assess the DBA's compliance with the contractual requirements of the SFC program as Virginia's Medicaid / FAMIS DBA.

Virginia's Medicaid non-emergency transportation brokerage services span across all seven (7) regions in Virginia. There is one (1) transportation brokerage company for Medicaid in Virginia. A biannual operational systems review will be conducted by the Contractor in order to assess the broker's compliance with the contractual requirements for transportation services.

Details about the Virginia Medicaid and FAMIS Programs can be found on the Department's website at: www.dmas.virginia.gov. The number of MCOs contracted with DMAS is subject to change at any time during the contract. ***The Department strongly recommends that Offerors visit the DMAS' website and become familiar with the Virginia Medicaid and FAMIS Programs***.

Federal regulations require that the Department evaluate the quality of services provided to Medicaid recipients enrolled in MCOs. It is also a priority of the Department to provide external quality review of services provided to the non-MCO participants of the (fee for services, for example) Medicaid programs and FAMIS. Throughout this RFP, when the term non-MCO appears, the intent is to describe participants in Medicaid or FAMIS who are enrolled in fee for service, or other delivery system that is not part of a managed care program.

By submitting a proposal, Offerors certify that all information provided in response to this RFP is true and accurate. Failure to provide information required by this RFP will ultimately result in rejection of the proposal.

Definitions

The following terms when used in this RFP shall be construed and/or interpreted as follows, unless the context expressly requires a different construction and/or interpretation.

- **Aid Category** - A numerical identifier for the VAMMIS of the covered group in which the person is enrolled.
- **Annual:** For the purposes of reporting requirements for the contract, resulting from this RFP, annual shall be defined as within 90 calendar days of the effective contract date and effective contract renewal date.
- **Appeals:** In accordance with 42 CFR § 438.400, an appeal is defined as a request for review of an action.
- **Benefits** – Services covered under the Virginia Medicaid Program.

- **Business Days**: Monday through Friday, 8:30 AM to 5:00 PM, Eastern Standard Time, unless otherwise stated.
- **Calendar Year**: January 1 through December 31.
- **Centers for Medicare & Medicaid Services (CMS):** The federal agency of the United States Department of Health and Human Services that is responsible for the administration of Title XIX and Title XXI of the Social Security Act.
- **Claim**: An itemized statement of services rendered by health care providers (such as hospitals, physicians, dentists, etc.), billed electronically or on the CMS 1500 or UB-92.
- **Client, Recipient, Enrollee, Member or Participant:** An individual having current Medicaid/FAMIS Plus eligibility who shall be authorized by the Department to participate in the Virginia Medicaid program.
- **Consumer Assessment of Health Plans (CAHPS)** - The term CAHPS refers to a comprehensive and evolving family of surveys that ask consumers and patients to evaluate the interpersonal aspects of health care. CAHPS surveys probe those aspects of care for which consumers and patients are the best and/or only source of information, as well as those that consumers and patients have identified as being important.
- **Contract:** The signed and executed document resulting from this RFP, including all attachments or documents incorporated by reference.
- **Contractor:** For the purposes of this RFP, the QIO that has entered into an agreement with the Department to provide external quality review services.
- **Contract Modifications:** Any changes or modifications to the Contract that are mutually agreed to in writing by the Contractor and the Department or are mandated by changes in federal or state laws or regulations as per Section 9.15.
- **Contract Year** – October 1 – September 30.
- **Department:** The Virginia Department of Medical Assistance Services (DMAS).
- **Dual Eligibles:** Medicare beneficiaries who are also enrolled in the Medicaid program.
- **External Quality Review Organization (EQRO)** - Is the organization with which the State contracts to evaluate the care provided to Medicaid enrollees.
- **FAMIS:** Family Access to Medical Insurance Security Health Insurance Program.
- **FAMIS Enrollee:** Persons enrolled in the Department's FAMIS program that are eligible to receive services under the State Child Health Plan under Title XXI, as amended.
- **FAMIS Plus Enrollees:** Children under the age of 19 who meet "medically indigent" criteria under Medicaid program rules. FAMIS Plus children receive the full Medicaid benefit package and have no cost-sharing responsibilities. Additionally, for the terms of the MCO Contract, FAMIS Plus and Medicaid enrollees are treated in the same manner. Any information sent to FAMIS Plus and Medicaid enrollees appropriately address the entire intended population. For example, all marketing and benefit materials that specify "Medicaid" will also specify "FAMIS Plus". If the material does not specify "Medicaid", it does not need to specify "FAMIS Plus"

- **Fee-for-Service:** The Department's traditional health care payment system in which physicians and other providers receive a payment for each unit of service they provide.
- **Fiscal Year (hereinafter "FY") (State):** July 1 through June 30.
- **Health Care Data:** Any information in any form or medium that relates to the past, present or future physical or mental health or condition of an individual; the provision of healthcare to an individual; or the past, present or future payment for the provision of health care to an individual.
- **Health Plan:** Managed Care Organization (MCO) or MEDALLION PCCM provider.
- **Health Insurance Portability & Accountability Act of 1996 (hereinafter "HIPAA")** - Title II of HIPAA requires standardization of electronic patient health, administrative and financial data; unique health identifiers for individuals, employers, health plans, and health care providers, and security standards protecting the confidentiality and integrity of individually identifiable health information past, present, or future.
- **Implementation Date:** The effective date of the contract.
- **Managed Care Organization (MCO):** In accordance with 42 CFR § 438.2, an entity that has qualified to provide the services to qualifying Medallion II or VALTC enrollees.
- **MEDALLION Program:** A primary care case management program (PCCM) delivered through DMAS where a recipient's health care is managed by a primary care provider (PCP) and providers are reimbursed on a fee-for-service basis for all covered services rendered and the PCP is reimbursed $3 per recipient per month (PMPM).
- **Medallion II Program:** A fully capitated, risk-based, mandatory Medicaid managed care program in which qualified Medicaid recipients choose between at least two contracted Managed Care Organizations. the contracted MCO receives a capitated PMPM payment that covers a comprehensive set of services, regardless of how much care is used by the recipient.
- **Medicaid Enrollee**: For purposes of this contract, any person identified by the Department as being eligible for services.
- **Offeror:** A person who makes an offer in response to a Request for Proposal.
- **Primary Care Case Management (PCCM):** The MEDALLION system under which a primary care case manager contracts with the Commonwealth to furnish case management services to recipients.
- **Recipient:** See Medicaid enrollee.
- **Secure email:** The generic term that usually applies to sensitive email being passed over the Internet in some form of encrypted format.
- **Shall:** A mandatory requirement or a condition to be met.
- **State:** Commonwealth of Virginia.
- **Subcontractor:** A State approved entity that contracts with the Contractor to perform part of the Contractor's responsibilities.
- **Virginia Acute and Long-Term Care Services (VALTC):** A mandatory managed care program that provides primary, acute, and long-term care services through one coordinated delivery system. Participants of VALTC include individuals in targeted areas of the Commonwealth who are enrolled in the Elderly or Disabled with

Consumer Direction (EDCD) long-term care program and individuals who receive both Medicare and Medicaid.

- **Virginia Medicaid Management Information System (VAMMIS):** The medical assistance eligibility, enrollment, and payment information system of the Virginia Department of Medical Assistance Services.
- **Virginia Medicaid Policy:** Includes the State plan, regulations, manuals and Medicaid memoranda.

III. RFP Objectives

The objective of this RFP is to identify and establish a contract with an Offeror that shall meet DMAS' requirements for external quality review (hereinafter "EQR") services. The Offeror must meet the CMS requirements, as defined by federal regulations (§ 42 CFR Part 438.354, Subpart E) AND have certification as a federally designated Quality Improvement Organization (QIO) formerly known as Peer Review Organization (PRO). The offering QIOs shall submit certification of their QIO status. "QIO-like entities," as defined by federal regulations shall not meet this minimum requirement. Qualified vendors, may submit a proposal with another QIO as a subcontractor (hereafter referred to in this RFP as the EQRO business partner) in order to provide the best fit for meeting the needs of the DMAS. The lead QIO (hereafter referred to in this RFP as the Offeror) must have certification as a federally designated QIO. Neither the Offeror nor its EQRO business partner can be listed as an Offeror or subcontractor in more than one proposal for RFP 2008-05.

The Offeror or its EQRO business partner must meet each of the following requirements:

- At least three years of experience interpreting and administering current federal requirements for Medicaid EQR, the federal EQR regulations released in January 2003 and protocols developed by CMS related to the EQR regulations. [1]

- At least three years of experience using federally mandated protocols to conduct on-site quality reviews of health plan adherence to contractual and regulatory requirements.

- Experience synthesizing Quality Compass data.

- At least three years of experience in CAHPS survey development and administration, and experience conducting Medicaid consumer satisfaction surveys.

[1] Department of Health and Human Services *42 CFR Parts 433 and 438,* Medicaid Program: External Quality Review of Managed Care Organization Federal Register, Volume 68. No 16

- At least three years of experience in validating performance improvement plans and measures implemented by health plans.

- Experience designing, conducting, synthesizing and reporting results from comprehensive needs assessments for at least two statewide projects.

- At least three years of experience of including Medicaid non-MCO data into Medicaid MCO focused study reports.

- At least three years of experience with producing EQR Technical Reports as specified in 42 Code of Federal Regulations (hereinafter "CFR") § 438.358.

- Experience assessing the expectations of its funding source regarding the outcomes and outputs of contract deliverables prior to the start-up of a task and throughout the duration of a task.

- Experience and ability in receiving (through secure file transfers), managing, and analyzing large data sets, such as encounter data.

- Experience building and maintaining collegial partnerships with managed care organizations, State agencies, and other key stakeholders with respect to healthcare quality improvement.

- Experience teaching healthcare quality improvement methods.

- Experience leading, managing, and facilitating collaboratives designed to improve healthcare.

- Ability to design, conduct, and report results on valid and reliable survey research using mail, in-person, and telephone methodologies.

- Certified by the National Committee for Quality Assurance (hereinafter "NCQA") as a Consumer Assessment of Health Plans Survey (hereinafter "CAHPS") vendor or subcontractor or has at least one completed CAHPS-related project in partnership with a certified NCQA CAHPS vendor or subcontractor

- Certified as an NCQA-HEDIS Compliance Auditor or subcontractor or has completed at least one HEDIS validation project in partnership with an NCQA-HEDIS Compliance Auditor or subcontractor.

- Prepared to rapidly respond to the needs and requests for in-person meetings with key customers in Virginia (DMAS, MCOs, key stakeholders).

The Offeror or its EQRO business-partner cannot be and cannot have plans to be an NCQA auditor for any of Virginia's Medicaid MCOs or have any business relationship with a Virginia Medicaid MCO that could be construed as a conflict of interest.

Task deliverables must include the following critical processes:

- Prior to the start-up of each task, the Contractor must schedule and facilitate a requirements gathering session onsite with DMAS to have a clear understanding of DMAS' expectations;
- The Contractor must have prior approval from DMAS on the outline that will be used in each report that it produces;
- The Contractor must provide at least 45 calendar days for DMAS to review a draft report;
- Final reports must be produced in a DMAS-approved format and must be available in electronic and hard copy versions per DMAS' request;
- Final reports that will be read by program and policy planners must include a 2-3 page stand-alone executive summary;
- Recommendations in reports must be specific and actionable.

IV. Scope of Work

It is important to note, the following tasks are subject to change based on federal, state and agency-level priorities. Changes to the scope of work would lead to contract negotiations and modifications. The tasks that shall definitely be included in the EQRO contract are marked throughout this RFP with a prefix of R (required). The tasks that may or may not be included in the awarded EQRO contract are deemed as being optional from DMAS' perspective and are marked throughout this RFP with a prefix of O (optional). Also, additional EQR may be required to conduct independent evaluations required by CMS for all new waivers granted to DMAS during the duration of the contract. Offerors are encouraged to submit innovative ideas for EQR tasks.

The contracted service shall include the tasks with a prefix of R and may include some, none, or all of the tasks with a prefix of O:

R-Task A. Contract Start-Up and Planning
R-Task B. Operations Preparedness
O-Task C. Provide Education and Communications on Quality Improvement
O-Task D. Facilitate and Manage Medicaid MCO Collaborative
R-Task E. Validate Medicaid MCO Performance Improvement Projects
R-Task F. Conduct Required Focused Studies
O-Task G. Conduct Optional Focused Study
R-Task H. Validate MCO Performance Measures
R-Task I. Assess Dental Services Vendor
R-Task J. Assess Transportation Services Vendor
R-Task K. Conduct Medicaid MCO Operational Systems Review
R-Task L. Conduct Needs Assessment for Virginia Acute and Long Term Care
R-Task M. Produce EQR Technical Report
R-Task N. Administer and Report on Consumer Satisfaction Surveys
R-Task O. PACE Site Compliance Review
R-Task P. Independent Review of FAMIS Appeals

R-Task A. Contract Start-Up and Planning

Within five (5) days from the award of Contract, the Contractor shall schedule and attend a meeting (entrance conference) at DMAS with the State's EQRO Contract Manager and other key staff to discuss all pertinent items relative to the Contract. The Contractor shall prepare and submit an Annual Work Plan (AWP) within five (5) business days after the entrance conference. The AWP shall be prepared in Microsoft MS Project and shall delineate each task, with milestones, and dates through the end of the first contract year. The Contractor and State will work together during initial Contract start-up to establish a schedule for key activities and define expectations for the content and format of Contract Deliverables for at least the first fiscal year.

Tasks A and B in the AWP shall be very detailed and will be used to monitor progress throughout the Transition Phase. The AWP will present the separate activities for each Transition Phase task and include:

- A logical sequence of tasks,
- A clear definition of each task,
- A specific completion date for each task,
- Task relationships and dependencies.

During this task, the Contractor will work closely with DMAS to define project management, status reporting standards, and communication protocols.

DMAS will:

1. Coordinate communications and act as a liaison between the new Contractor and the incumbent Contractor;
2. Coordinate the transfer of files from the incumbent Contractor to the new Contractor on a schedule outlined in the approved work plan;
3. Provide all available relevant documentation on operations currently performed by the incumbent Contractor and DMAS;
4. Establish protocols for problem reporting and controls for the transfer of data or information from the incumbent Contractor to the new Contractor;
5. Work with the Contractor to review and finalize the project work plan for the Transition Phase;
6. Assign a DMAS' liaison to participate in Contractor work groups;
7. Review and approve procedure and protocols defined by the work groups; and
8. Monitor progress through periodic status reports, weekly meetings, and work plan updates.

The new Contractor shall:

1. Finalize the AWP, including the Transition Phase activities and submit it to DMAS for approval;

2. Work with DMAS to establish communication protocols between the new Contractor and DMAS;
3. Weekly meetings will be held throughout the Transition Phase to discuss and resolve transition issues, establish procedures and protocols to support operations, and promote communications among all parties;
4. Work with DMAS to establish project management and reporting standards;
5. Submit periodic written status reports on the progress of tasks against the approved work plan; and
6. Conduct periodic status meetings with DMAS. The new Contractor is responsible for preparing the agenda for the meetings and preparing and distributing minutes, to include action items, from each meeting.

Deliverable: DMAS' approved annual work plan within 10 working days of contract start date. Weekly status reports are due to DMAS by end of business day each Friday until deemed no longer necessary by DMAS. Each year thereafter, the EQRO shall provide DMAS with an annual workplan, which will be due August 15, 2009 and 2010.

R-Task B. Operations Preparedness

During the operations preparedness task, the Contractor will install and test all hardware, software, and telecommunications required to support the contract.

DMAS will:

1. Identify a Project Transition Team that will be charged with managing all transition activities;
2. Act as a liaison between the new Contractor and incumbent Contractor during the development of the transition plan and schedule for the operations cross-over;
3. Communicate project progress to interested parties, including DMAS' senior management and the MCOs, on a periodic basis;
4. Assess the Contractor's understanding of its responsibilities and capability to assume the functions required under the Contract.

The Contractor shall:

1. Install, test and report findings to DMAS for all hardware, software, and telecommunication capabilities.
2. Participate in defining and testing minor modifications to existing data extraction processes;
3. Meet with stakeholders on a periodic basis to discuss progress;
4. Hire and train staff to assume the operations responsibilities in the contract scope of work;
5. Conduct orientation and training for DMAS' personnel on Contractor organization, functional responsibilities, and operational procedures;

6. Prepare a Coordination Plan that documents how the Contractor will coordinate its business activities with those activities performed by other vendors. The Contractor will update the information in this document throughout the life of the Contract;
7. Ensure that Task B is part of the AWP and is a detailed component of the AWP;
8. Develop, and submit for State review and approval the following: disaster recovery, data security, and physical plan security procedures; and
9. Provide test data to all interfaces.

Deliverables: An operations preparedness plan shall be included as part of the annual work plan in Task A. The operations preparedness plan is due to DMAS within ten (10) working days of contract start date. The disaster recovery plan is due within 30 days of contract start date.

O-Task C. Provide Education and Communications on Quality Improvement

Task: The EQRO will provide up to 350 hours per contract year of quality improvement education and communications to DMAS and to MCOs. This task is separate from the collaborative.

Purpose: The Contractor will be positioned as a pre-paid quality improvement consultant for DMAS and MCOs. The Contractor will provide education that further enables DMAS and the MCOs to understand the industry standards for continuous quality improvement in healthcare processes, systems, programs, clinical guidelines, and policies.

Methodology: Education may be in the form of face-to-face presentations, meeting facilitation, review and recommendations to improve upon the DMAS' quality strategy, web-based presentations, conference calls, desk-review of quality related documents. Communications may include a notice and synthesis of new and relevant federal regulations, synthesis and presentation of MCO HEDIS scores, notice of industry best practices, and notification and summary of nationally recognized clinical guidelines. In addition, DMAS may request that the Contractor respond rapidly to the need for ad-hoc reports. The hours for this task shall also include preparation, implementation, and evaluation of education and communications.

Correspondence: The Contractor will be expected to deliver the education and communications in the most effective and efficient way. The Contractor is expected to set-up and maintain a secure (accessed by DMAS, EQRO, and Medicaid MCOs, with user IDs required) web portal for communications and education for FAMIS and Medicaid quality.

Analysis and Reporting: The Contractor will be expected to be proactive in identifying the needs and interests of DMAS and the MCOs with regards to education and communications. The Contractor shall maintain documentation and reports on education

and communications. Documentation and reports shall include who participated and a measure of satisfaction among participants.

Deliverables: By January of 2009, the Contractor shall have a process in place whereby DMAS and MCOs can request education from the Contractor. By January of each year, the Contractor shall have finalized its communications plan for the calendar year. The plan will have been developed in consultation with DMAS.

O-Task D. Facilitate and Manage Medicaid MCO Collaborative

Task: The Department currently contracts with five Medicaid MCOs. Through the contract between DMAS and each MCO, the MCOs are required to participate in the quality collaborative, which has been facilitated by DMAS since 2006. The collaborative has functioned as a forum where the MCOs share ideas on how to improve specific quality measures, such as childhood immunizations and well-child visits. DMAS would like to transform the collaborative from being an information sharing forum to a quality improvement collaborative, similar in nature to the learning collaborative model designed by the Institute for Healthcare Improvement (IHI).

The pilot collaborative will focus on improving MCO and MCO-aggregate scores for the childhood immunization (up to age 24 months) Medicaid HEDIS measures. The EQRO should plan for a 16 month pilot-collaborative, with quarterly meetings, beginning in March 2009 and ending in July 2010 with an outcomes congress. The collaborative will also integrate the CMS mandated EQR requirement found in 42 CFR § 438.358(b)(1) which requires validation of performance improvement projects (PIPs). See Task E in this RFP for deliverables relevant to the PIPs validation. Childhood immunizations will be one of two PIPs that the MCOs will be required to produce, and will be the only one that is addressed as part of the collaborative.

Purpose: The collaborative will enable the Medicaid MCOs to plan, implement, and measure rapid cycle process improvements that could lead to an increase in childhood immunization rates among Medicaid MCO enrollees.

Methodology: The EQRO should plan to model the collaborative after the IHI's model for learning collaboratives. The EQRO could adjust the IHI model to make it effective and efficient for DMAS and the Medicaid MCOs. The EQRO should plan to provide the MCOs with a collaborative tool-kit at the beginning of the pilot and at the beginning of the second collaborative. The tool-kit will be a trusted source-manual for the MCOs to use throughout each collaborative. Additions/changes to the manual should be made as needed. DMAS anticipates that the collaborative meetings would occur quarterly in Richmond, Virginia, at a location to be determined by DMAS and the Contractor.

Correspondence: The EQRO will be responsible for developing, administering, managing, and evaluating the collaborative. The EQRO will communicate directly with the MCOs and DMAS. The EQRO must engage each MCO (at the request of DMAS) and DMAS in the review of preliminary findings and draft reports.

Analysis and reporting: The primary data sets for baseline, re-measurement, and for tracking progress will be HEDIS scores. However, the EQRO should propose methods for interim measurement in order to track progress over time. The EQRO should integrate national benchmarks, national and state means, and targets into tracking progress over time. The EQRO is also expected to conduct an evaluation of the pilot collaborative in order to make a recommendation to DMAS on whether to conduct a second collaborative. The recommendation should be justified by feedback from the MCOs and outcomes from the pilot collaborative.

Deliverables: The EQRO will provide an evaluation of the collaborative that will include an executive summary, topic background, collaborative methodology, description (quantitative and qualitative) of progress being made, lessons learned, barriers, and process and systems changes the MCOs made that were relevant to the specific goals of the collaborative. In addition, the EQRO should describe program and policy changes that were made by DMAS as a result of the collaborative experience. DMAS will be provided with a draft of the evaluation reports for review and comment. The primary audience for the evaluations will be policy, program and technical professionals from DMAS and the MCOs. The evaluation will also be posted on the DMAS' internet site. The pilot collaborative evaluation is due on November 1, 2010.

The toolkit for the collaborative will be reviewed and approved by DMAS and available for use at the first meeting of the MCO pilot Collaborative in March of 2009.

Within 30 calendar days of each collaborative meeting, the EQRO will distribute meeting summaries, action items, and responses to questions raised during each collaborative meeting. DMAS must approve these items prior to distribution.

R-Task E. Validate Medicaid MCO Performance Improvement Projects

Task: Annually, the EQRO will validate each performance improvement project (PIPs) developed by the MCOs on two quality measures (clinical or administrative). The validation process for one of the PIPs (increasing childhood immunization rates) will be integrated into the collaborative referenced in Task E of this RFP. Each MCO will select its second PIP topic, based on needs for improvement indentified in HEDIS scores and/or their managed care operations systems review. The MCOs will be required to receive DMAS' approval for the PIP topic of choice.

Purpose: The PIPs validation is a CMS mandated EQR activity that must be completed every twelve months. The PIPs validation is designed to assist the MCOs in practicing effective continuous quality improvement to improve the care received by Medicaid enrollees. DMAS plans to continue requiring that each MCO submit PIPs annually for validation by the EQRO.

Methodology: The EQRO should expect to follow the CMS recommended protocol for PIPs validation, "Validating Performance Improvement Projects, A protocol for use in Conducting Medicaid External Quality Review Activities, Final Protocol, Version 1.0,

May 1, 2002." However, DMAS welcomes ideas in this proposal that would add value to CMS's recommendations. With NCQA accreditation, the MCOs follow HEDIS technical specifications for annual quality measures, and as such, the PIPs validation elements that are already met through HEDIS audits, will be deemed as having been met for the PIPs validation process.

Correspondence: The EQRO is expected to position itself as a technical consultant for the MCOs during the PIPs and the PIPs validation process. The EQRO should be a source for knowledge sharing and for sharing best practices for Medicaid MCO performance improvement projects. In addition, the EQRO is expected to have ongoing dialogue with DMAS during the PIP validation process. The EQRO must engage each MCO and DMAS in the review of preliminary findings and the draft PIPs validation reports.

Analysis and reporting: The EQRO should propose methods for tracking the development of the PIPs and the validation of the PIPs. The EQRO should follow the CMS guidance for the PIP validation report content, and should propose additional content that would add value to supporting continuous quality improvement.

Deliverables: A separate PIPs validation report for each MCO and an aggregate report that summarizes all of the PIPs validations. PIPs validation reports are due annually as follows: September 1, 2009, September 1, 2010, and September 1, 2011.

R -Task F. Conduct Required Focused Studies

The Contractor shall perform focused studies that are intended to provide a synthesis of relevant data, evidence-based literature, and population health improvement needs relating to a specific topic that is a high priority for quality improvement. The topics will expand beyond the MCO enrollees to include all of Virginia's Medicaid and SCHIP recipients. The topics, and the details of the methodology, of focused studies i – iv are subject to change based on federal and state requirements in addition to new waivers and agency goals.

R-F.i. Improving Birth Outcomes through Adequate Prenatal Care

Task: The EQRO shall conduct a focused study, using the CMS protocol set forth in the document titled: "Conducting Focused Studies of Health Care Quality," Final Protocol, Version 1.0, May 1, 2002" for use in Conducting Medicaid External Quality Review Activities. The EQRO should assume that the study population(s) will include, and shall be analyzed, synthesized, and reported in aggregate and stratified as follows:

- Medicaid eligible due to pregnancy
    - By Program:
        - SSI
        - FAMIS

        - Medicaid Expansion
        - FAMIS Plus (under 21)
        - Medicaid eligible due to pregnancy
        - Other Medicaid
        - FAMIS Moms

    - By Delivery System:
        - FFS
        - PCCM
        - MCO

    - By Race:
        - Caucasian
        - African-American
        - Asian
        - Hispanic
        - Other

Purpose: To provide quantitative and qualitative information that will enable policy and program planners to implement effective strategies to improve birth outcomes through adequate use of prenatal care services.

Methodology: Data used by the EQRO should include HEDIS scores, claims data, and encounter data. Medical record abstraction is not required for this study. HEDIS technical specifications shall be used as the model for methodology.

Correspondence: The EQRO is responsible for communicating progress made to the DMAS. The EQRO must engage each MCO and DMAS in the review of preliminary findings and draft focused study reports.

Analysis and Reporting: Results shall be reported for all FAMIS, FAMIS Plus, FAMIS MOMS, Medicaid eligible due to pregnancy, and other Medicaid by program, delivery system, and race. The focused study report shall follow the recommended seven steps from the Focused Study Protocol and include a section on conclusions, key findings and recommendations. The report shall also contain a stand-alone executive summary.

Pregnant women will be compared with national and Virginia statewide averages and benchmarks when feasible. The analysis and report shall also answer the following questions:

- Number of enrolled women in all programs who received the recommended number of prenatal visits.
    - Data presented by program and race
    - Data presented by delivery system and program

- Number of women enrolled by trimester in FAMIS MOMS or Medicaid for pregnant women.
  - Data presented by race and program
  - Data presented by delivery system and program

- Number of infants born to all (seven) programs with low or very low birth-weight
  - Data presented by program and race
  - Data presented by delivery system and program
  - Data presented by trimester of enrollment
  - Data presented by women receiving the recommended number of prenatal visits

- Number of infants born premature to all (seven) programs
  - Data presented by program and race
  - Data presented by delivery system and race
  - Data presented by trimester of enrollment
  - Data presented by women receiving the recommended number of prenatal visits

Deliverables: At the conclusion of the study, a draft report of study results will be submitted, and a final report will be delivered, after the Department has reviewed and commented on the draft report. The final report is due on Sept 15, 2009. Each June 30th thereafter, an annual update on the data shall be provided to DMAS in order to track progress over time.

R-F.ii. Well-Child Focused Study

Task: The EQRO shall conduct a focused study using the CMS protocol set forth in the document titled: "Conducting Focused Studies of Health Care Quality," Final Protocol, Version 1.0, May 1, 2002" for use in Conducting Medicaid External Quality Review Activities. The EQRO should assume that the study population(s) will include three programs: FAMIS, Medicaid Expansion, and FAMIS Plus; and three delivery systems: FFS, PCCM, and MCO.

Purpose: To provide quantitative and qualitative data on the extent that Virginia's SCHIP and Medicaid enrollees are receiving the recommended well-child healthcare services. The health services that shall be addressed in the study include: immunizations, asthma management, PCP access, and well child visits.

Methodology: Data used by the EQRO should include HEDIS scores, claims data, encounter data, and random samples of medical record reviews. The EQRO should describe, in its response to this RFP, its method for selecting a random sample of medical records from providers; describe its method for receiving a

statistically valid number of medical records that are requested; and its method for developing and testing the medical record abstraction tools.

- Methodology for immunizations shall follow HEDIS technical specifications and shall be limited to the age category of birth-24 months
- Methodology for asthma management shall follow HEDIS technical specifications
- Methodology for well-child visits shall follow HEDIS technical specifications and shall be analyzed and reported for each of the following age groups:
    - Up to first 15 months
    - 3 years of age
    - 4 years of age
    - 5 years of age
    - 6 years of age
    - 7-11 years of age
    - 12-21 years of age
- Methodology for PCP access shall follow HEDIS technical specifications

The Contractor should be mindful that there are no financial incentives or disincentives for providers to submit medical records upon request by the EQRO. Given this barrier, response rates to medical record requests are typically around 50%. The Contractor should plan for follow-up and propose methods (such as over sampling) for obtaining adequate sample sizes.

Correspondence: The EQRO is responsible for communicating progress to DMAS. The EQRO must include the MCOs and DMAS in the review of preliminary findings and draft focused study reports.

Analysis and Reporting: Results shall be reported for each topic (immunizations, asthma, well-child visits, and PCP visits) and presented by the three applicable programs and three delivery systems. All data shall also be further stratified by race. The focused study report shall follow the recommended seven steps from the Focused Study Protocol and include a section on conclusions, key findings and recommendations. The report shall also contain a stand-alone executive summary.

Deliverables: At the conclusion of the study, a draft report of study results will be submitted, and a final report will be delivered after the Department has reviewed and commented on the draft report. The final report is due on November 15, 2009. The Contractor shall also provide an annual update to the data in order to track data over time. The annual update is due on November 15, 2010.

R-F-iii. Reducing the Risk of Emergency Cardiovascular Events Among Adults with Chronic Disease through Better Control of Blood Pressure and Cholesterol.

Task: The EQRO shall conduct a focused study using the CMS protocol set forth in the document titled: “Conducting Focused Studies of Health Care Quality,” Final

Protocol, Version 1.0, May 1, 2002" for use in Conducting Medicaid External Quality Review Activities. The EQRO should assume that the study population will include MCO and fee-for-service enrollees who are aged 18 and older. In addition, the study may include adults (age 21 and older) enrolled in the Virginia Acute and Long-Term Care (VALTC) program, which will be administered by MCOs. The following focused study question will be a topic: *Does better management of blood pressure and cholesterol in a high-risk population reduce the rate of unplanned ED visits and unplanned hospitalizations for cardiovascular events?*

Purpose: To provide quantitative and qualitative information that will enable policy and program planners to implement effective strategies for increasing blood pressure and cholesterol management among the Medicaid adult population.

Methodology: Data used by the EQRO should include HEDIS scores, claims data, encounter data and a random sample of medical record reviews. The EQRO should describe its method for selecting a random sample of medical records from providers; describe its method for actually receiving a statistically valid number of medical records that are requested; and its method for developing and testing the medical record abstraction tools.

The Contractor should be mindful that there are no financial incentives or disincentives for providers to submit medical records upon request by the EQRO. Given this barrier, response rates to medical record requests are typically around 50%. The Contractor should plan for follow-up and propose methods (such as over sampling) for obtaining adequate sample sizes.

Correspondence: The EQRO is responsible for communicating progress to DMAS. The EQRO must include the MCOs and DMAS in the review of preliminary findings and draft focused study reports.

Analysis and Reporting: Results shall be reported for the Medicaid MCO and fee-for-service adult population and shall include separate analysis and reporting on the VALTC population. The focused study report shall follow the recommended seven steps from the Focused Study Protocol and include a section on conclusions, key findings and recommendations. The report shall also contain a stand-alone executive summary.

Deliverables: At the conclusion of the study, a draft report of study results will be submitted, and a final report will be delivered, after the Department has reviewed and commented on the draft report. The final report is due on July 30, 2011.

O-G. Conduct Optional Focused Study: Common Barriers that are Preventing Children from Keeping Dental Appointments

Task: The EQRO shall conduct a focused study using the CMS protocol set forth in the document titled: "Conducting Focused Studies of Health Care Quality," Final

Protocol, Version 1.0, May 1, 2002" for use in Conducting Medicaid External Quality Review Activities. The EQRO should assume that the study population(s) will include both Medicaid MCO and non-MCO enrollees of Medicaid and/or SCHIP. The following focused study question will be the topic: *Does the utilization of routine dental visits among children enrolled in the Smiles for Children Program increase when barriers to keeping scheduled appointments decrease?*
Purpose: To provide quantitative and qualitative information that will enable policy and program planners to implement effective strategies for increasing the utilization of dental care among children in the Smiles for Children program.

Methodology: Data used by the EQRO should include claims data, encounter data and qualitative data collected from consumers. Quantitative analysis should include stratification identification of disparate sub-populations.

In order to collect qualitative data to gain further insight on reasons for and potential solutions to the reasons why many appointments are not kept. The EQRO may sub-contract with a vendor to conduct and report on focus groups and/or in-person interviews with parents or guardians of children with the Smiles for Children benefit.

Correspondence: The EQRO is responsible for communicating progress to the DMAS. The EQRO must engage DMAS and the dental vendor in the review of preliminary findings and draft focused study reports.

Analysis and Reporting: Results shall be reported on participants in the Smiles for Children program. The focused study report shall follow the recommended seven steps from the Focused Study Protocol and include a section on conclusions, key findings and recommendations. The report shall also contain a stand-alone executive summary.

Deliverables: At the conclusion of the study, a draft report of study results will be submitted, and a final report will be delivered, after the Department has reviewed and commented on the draft report. The final report is due on June 15, 2010.

R-Task H. Validate MCO Performance Measures

Task: To meet a CMS EQR mandated activity for validating performance measures, the EQRO will validate a select group of each MCO's HEDIS scores on an annual basis. The EQRO should plan to validate scores for the same two HEDIS measures for each MCO. The selected measures for validation will be determined by DMAS on an annual basis and will be contingent upon concerns related to particular HEDIS scores.

Year 1 quality measures for validation:

- Childhood immunization rates for ages up to 24 months – 2008 HEDIS scores that are reported by the MCOs in August of 2008 will be validated

- Prenatal visits – 2008 HEDIS scores that are reported by the MCOs in August of 2008 will be validated

Year 2 quality measures for validation:
Two measures to be determined.

Year 3 quality measures for validation:
Two measures to be determined.

Purpose: The performance measure validation is a CMS mandated EQR activity that must be completed every twelve months. Two HEDIS scores will be the focus for validations each year.

Methodology: The EQRO should expect to follow the CMS recommended protocol for validating performance measures, "Validating Performance Measures, A protocol for use in Conducting Medicaid External Quality Review Activities, Final Protocol, Version 1.0, May 1, 2002."

Correspondence: The EQRO is expected to have ongoing dialogue with each MCO to enable the MCOs to adequately prepare for the onsite visit for the performance measure validation process to take place in an efficient and effective manner. The EQRO must engage each MCO and DMAS in the review of preliminary findings and draft quality measure validation reports.
Analysis and reporting: The EQRO is expected to complete a performance measure validation worksheet for each MCO's two measures. The EQRO will also produce an aggregate report that de-identifies the MCOs, and summarizes strengths, weakness, opportunities for improvement, and threats (SWOT) to the reporting of valid scores by the MCOs.

Deliverables: The EQRO will produce a separate performance measure validation worksheet for each MCO's measures that are validated. A SWOT analysis report on the validity of the quality measures that are reported by the MCOs will also be provided to DMAS.

Performance measure validation reports (worksheets and aggregate SWOT analysis) are due annually as follows: September 1, 2009, September 1, 2010, and September 1, 2011.

R-Task I. Assess Dental Services Vendor

Task: Biannually, the Contractor shall perform a review of the DBA adherence to its contract with DMAS. Specifications for the biennial review may change over the course of the contract.

Purpose: To measure the level of adherence and identify opportunities for improvement regarding the DBA's adherence to DMAS' contractual requirements.

Methodology: The Contractor will evaluate the DBA's policies and procedures to ensure adherence to DMAS' contractual requirements. The review of the documents and evidence of their use will be conducted at the location of the DBA's operations, which is currently located in Wisconsin. The review will include, but is not limited to, the policies and procedures for the DBA's following elements:

- Disaster recovery plans.
- Claims submission and processing.
- Complaints, grievances and appeals.
- Quality assurance programs.
- Utilization (over and under) tracking and review.
- Administration of Member/Provider Satisfaction Surveys.
- Compliance with handling of Protected Health Information.

Analysis and Reporting: The Contractor shall produce a detailed report that describes the manner in which the data from all activities were aggregated, analyzed, and conclusions drawn as to the DBA's effectiveness in real application of the contractual obligations. The report must include: 1) introduction and purpose; 2) technical methods of data collection and analysis; 3) data obtained; 4) detailed assessment of strengths, weaknesses and opportunities for improvement (with actionable recommendations) and 5) an assessment on the degree to which the DBA addressed recommendations from previous reviews and action taken to improve upon the unmet and partially met elements from the last report. The report must also contain a 2-3 page executive summary. The report should be written for an audience of program and policy makers.

Correspondence: Contractor will disseminate a letter to the DBA that outlines the required documentation and how it should be organized for the onsite review. The Contractor is also responsible for scheduling the onsite review with the contractor, developing an agenda, and describing the role of the Contractor and role of the DBA. The EQRO must include the DBA and DMAS in the review of preliminary findings and draft PIPs validation reports.

Deliverables: At the conclusion of the onsite review, a draft report of study results will be submitted, and a final report will be delivered after the Department has reviewed and commented on the draft report. The draft and final reports shall contain a 2-3 page executive summary. The report is due on October 15, 2009 and April 30, 2011.

R-Task J. Assess Transportation Services Vendor

Task: Biannually, the Contractor shall perform an assessment of the non-emergency transportation broker's adherence to the contractual requirements of DMAS.

Purpose: To review issues of quality transportation services.

Methodology: The Contract will evaluate the Broker's policies and procedures to ensure adherence to federal guidelines and DMAS' contractual requirements. The review will include, but is not limited to the following elements:

- Review of the Broker's public transit plan and its effectiveness.
- Comparison of paid transportation claims vs. billed transportation claims for ambulatory, wheelchair van and non-emergency ambulance.
- Examination of claims paid by the Broker (including mileage calculations).
- Comparison of call center performance reports vs. call management system computed data.
- Evaluation of Broker's quality assurance performance including vehicle inspections, driver credentialing, field monitoring and complaint logs.
- Review trip approval and denial practices to ensure that decisions are made in compliance with written policies and procedures and that the program reflects the standards.

Analysis and Reporting: The Contractor shall produce a detailed technical report that describes the manner in which the data from all activities were aggregated, analyzed, and conclusions drawn as to the quality of care furnished by the Broker. The report must include: 1) objectives; 2) technical methods of data collection and analysis; 3) data obtained; 4) detailed assessment of strengths and weaknesses and 5) an assessment of the degree to which the Broker addressed recommendations from previous reviews. The report must contain a one –page summary with conclusions readable by laypersons that clearly outline areas of compliance and non-compliance, excellence, and those in need of improvement.

Correspondence: Contractor will disseminate a letter to the Broker requesting audit documentation and scheduling availability. The EQRO must include the transportation broker and DMAS in the review of preliminary findings and draft reports.

Deliverables: At the conclusion of the study, a draft report of study results will be submitted, and a final report will be delivered after the Department has reviewed and commented on the draft report. The draft and final reports shall contain a 2-3 page executive summary with conclusions readable by policy and program planners. The report is due on October 15, 2009, and June 15, 2011.

R-Task K. MCO Operational Systems Review (OSR)

Federal regulations mandate that the EQRO complete a comprehensive administrative review every three years to determine compliance with federal and state program requirements. The most recent comprehensive administrative review took place during the first and second quarters of calendar year 2008. The next comprehensive review will take place in FY 2011.

Currently, there are national accrediting bodies, such as the NCQA, that accredit a

variety of organizations based on an independent review of the organization against a set of established administrative and clinical standards. As of the release of this RFP, all five of the Medicaid MCOs the Department contracts with are NCQA accredited. Based on the federal regulations, the MCOs, with evidence of national accreditation within a previous three-year period, may be exempt from a review of certain administrative functions, when the accrediting organization's standards are comparable to the federal and state program requirements.

The EQRO shall conduct the comprehensive compliance review on each Medicaid MCO during the FY2011 . During the FY2009 and FY2010 , the EQRO shall conduct a modified compliance review on each MCO.

The comprehensive compliance review is outlined in Task K.i and the modified compliance review is outlined in Task K.ii.

Task K.i: The Contractor shall perform a modified OSR of each MCO to assess the level of progress that each MCO is achieving on the expectations outlined by DMAS in the respective Medallion II annual contract and on the elements of the most recent comprehensive OSR that were identified as opportunities for improvement (assessed as partially met or unmet).

Purpose: To assess the level of progress the MCOs are making on their contractual obligations and on progress made toward improving the comprehensive OSR unmet and partially met elements.

The 2010 deliverable shall also include review of the MCOs' contract compliance with the 1915(C) waiver. Specifically, the 1915 (C) waiver-VALTC requirements to ensure that the level of care policies and procedures are appropriate, in compliance with requirements, and adhered to. In addition, the EQRO shall determine if the service planning policies and procedures are being followed by the MCO. The EQRO shall accomplish this through review of a sample of medical records with a validation tool while onsite for the OSR.

Methodology: The modified OSR will take place midpoint of each MCO contract year (which begins July 1 of each year) that the comprehensive OSR does not occur. The Contractor shall conduct the modified review during a two-day onsite meeting at an office of each MCO. At least six weeks prior to the onsite meeting, each MCO will receive, from the Contractor, a list (approved by DMAS) of specific documentation and/or subject matter experts that will need to be available to the Contractor during the onsite modified OSR.

Analysis and Reporting: The EQRO shall prepare a memo to DMAS within 10 working days after the onsite modified OSR that outlines any deficiencies that were identified. This rapid-cycle feedback is imperative to enable DMAS to intervene with any MCO that may not be meeting contractual requirements or making progress on meeting the contractual requirements with DMAS.

Correspondence: Contractor will coordinate scheduling onsite OSR with each MCO directly. The EQRO must engage the MCOs and DMAS in the review of preliminary findings and draft reports.

Deliverables: The modified OSR will be conducted and a memo of deficiencies will be provided to DMAS no later than ten working days after each modified OSR is conducted. The memos will be due in February 2009 and February 2010.

Task K.ii. Conduct Comprehensive Medicaid MCO Operation Systems Review (OSR)

Task: The Contractor shall perform an onsite review of each of the MCOs operational systems as mandated by CMS through 42 CFR § 438.358(b)(3). The EQRO should plan to follow the protocol recommended by CMS in its document titled: "Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPS): A Protocol for Determining Compliance with Medicaid Managed Care Proposed Regulations at 42 CFR Parts 400, 430, et al., Final Protocol Version 1.0, February 11, 2003." The MCOs that are accredited by NCQA for their Medicaid line-of-business will be exempt from the duplicative review activities (see Attachment G for the current list of duplicative activities per NCQA, which is subject to change). Specifications for the annual MCO reviews may change over the course of the contract, as federal regulations or state requirements change. The EQRO should expect the comprehensive OSR to occur once every three years, beginning with FY 2011.

- Enrollee Rights and Protections—Subpart C Regulation
- Quality Assessment and Performance Improvement—Subpart D Regulation
- Grievance Systems—Subpart F Regulation

Methodology: The EQRO will conduct the seven step recommended protocol that is outlined by CMS. The seven steps are: plan for compliance monitoring activities; obtain background information from DMAS; review documents; conduct interviews, collect any other accessory information, analyze and compile findings, and report results to DMAS. The EQRO should plan to schedule up to five consecutive calendar days at each MCO for the document review, interviews, and preliminary findings meeting with the MCO. The MCOs will not be expected to provide the EQRO with the documents in advance of the onsite OSR.

Analysis and Reporting: The Contractor shall produce a detailed technical report about the results of each MCO's OSR and, where applicable, a summary of components of each plan's NCQA accreditation elements that were not included in the OSR because they were deemed duplicative. The technical report shall also include concrete and actionable recommendations for improving unmet and partially met elements from the OSR.

Correspondence: The Contractor shall provide training and ongoing communications to the MCOs and DMAS on the process, timeline, and expectations to enable the OSR process is methodical, efficient, and effective.

Deliverables: At the conclusion of the study, a draft report of study results will be submitted, and a final report will be delivered after the Department and the MCOs have reviewed and commented on the draft report. The EQRO shall provide a detailed technical report for each MCO and a comprehensive aggregate report on all of the MCOs. The final report on each MCO and the final comprehensive report will be due June 1, 2011.

R-Task L. Conduct Needs Assessment for Virginia Acute and Long Term Care Program

Task: The Contractor shall perform a needs assessment on the quality improvement needs for the VALTC. The VALTC is a pilot project that is scheduled to begin at or around February of 2009. The needs assessment will begin in February 2010, which is approximately one year after the implementation of the VALTC. The EQRO shall assess the MCO/DMAS' processes and participant outcomes of the VALTC, and will make recommendations on the clinical and administrative priority areas that need improvement in order to improve enrollee experience and outcomes.

Purpose: To establish a needs-based approach to continuous quality improvement of the VALTC program and to recommend a focus for quality improvement for the next several years.

Methodology: The Contractor will develop the methodology, the tools, and a report on the VALTC's areas for improvement. The Contractor will have access to the standardized level of care documents, claims and encounter data, and will be responsible for conducting interviews with a sample of participants and a sample of providers.

Analysis and Reporting: The Contractor shall produce a detailed report that includes: 1) introduction and purpose; 2) technical methods of data collection and analysis; 3) data synthesis; 4) detailed assessment of strengths and weaknesses and 5) identification and justification of greatest opportunities for improvement 6) concrete recommendations on best practices/evidence-based literature that, if implemented in the VALTC, would result in measurable improvement. The report must contain an executive summary that clearly outlines areas of excellence, and those in need of improvement.

Correspondence: The EQRO must include each MCO and DMAS in the review of preliminary findings and draft reports. Since this is a new program, it is imperative that the EQRO conduct a requirements gathering session with DMAS prior to proceeding with the planning and implementation of this task.

Deliverables: At the conclusion of the study, a draft report of study results will be submitted, and a final report will be delivered after the Department has reviewed and commented on the draft report. The report is due on August 15, 2011.

R-Task M. Produce EQR Technical Report

Task: The Contractor shall prepare and provide the Annual Technical Report (ATR) to DMAS using the recommended template in Table A, from the CMS protocol document titled "State External Quality Review Tool Kit for State Medicaid Agencies", October 2006. The EQRO shall include both MCO and non-MCO tasks in the ATR.

Purpose: To provide a review of the external quality review process, major findings from the tasks completed, and recommendations for DMAS and the MCOs.

Methodology: Prior to initiating the report, the EQRO shall ascertain the expectations that DMAS has for content and format. The EQRO shall use the CMS template and gather the recommended information in a timely and methodical manner. The EQRO will provide DMAS with a draft of the report for review and comment.

Correspondence: Contact remains between DMAS and the Contractor.

Analysis and Reporting: The ATR shall include the recommended content outlined by CMS in the template. In addition to having a focus on MCOs, the EQRO shall include non-MCO enrollee programs in the report, where applicable.

Deliverables: The Contractor shall provide the Department with a draft and final ATR. The report shall contain a 2-3 page executive summary suitable for use by CMS, the Office of the Governor, the Virginia Legislature, and conclusions readable by program and policy makers. The report is due on December 15, 2009, which shall cover the 2009 EQRO contract year and December 15, 2010, which shall cover the 2010 EQRO contract year.

R-Task N. Administer Assessments and Report on Consumer Satisfaction

R-Task N.i Comprehensive Assessment and Report on Consumer Satisfaction:

In calendar year 2010 the Medicaid MCOs will administer the NCQA CAHPS survey in compliance with NCQA technical specifications. The Department finds value in assessing customer satisfaction among enrollees in all of the Department's programs. In order to assess consumer satisfaction among enrollees who are not covered by an MCO (such as Fee-for-Service, SCHIP) the EQRO will develop and administer a CAHPS-like survey. The end result will be a

report that synthesizes the CAHPS survey results and the CAHPS-like survey results.

Purpose: The report will be used to identify opportunities for improvement and to enhance, if needed, health benefits design, programs, and education and training to MCOs, DMAS employees, and/or providers.

Methodology: Data collection for the CAHPS-like survey should be completed by the end of the second quarter of 2010 calendar year. The EQRO should recognize that response rates are typically low with CAHPS-like surveys, and should design methodology that will aim toward having response rates that will provide meaningful results.

Analysis and Reporting: The EQRO shall produce an annual customer satisfaction report that includes the CAHPS and the CAHPS-like surveys: 1) an executive summary not to exceed 2-3 pages; 2) description of methods of data collection and analysis 3) summarized assessment of each program's strengths and weaknesses with respect to customer satisfaction, and, when feasible, data that have been trended over time; 4) Summary of disparities that exist between customer satisfaction between the different programs; and 5) Recommendations for actionable next steps toward improvement.

Correspondence: The Contractor shall engage DMAS in on-going communication regarding methodology and enrollment data needs.

Deliverables: At the conclusion of the study, a draft report of study results will be submitted, and a final report will be delivered, after the Department has reviewed and commented on the draft report. The annual customer satisfaction final report is due to DMAS by February 28, 2011.

R-Task N.ii Modified Consumer Satisfaction Assessment

Task: During the calendar years when MCOs are not administering CAHPS surveys to enrollees, the EQRO shall identify one of the composites from the most recent CAHPS and CAHPS-like surveys that were identified as having an opportunity for improvement among all programs. In 2009 and 2011 the EQRO will administer a survey to recipients in Medicaid MCO, FFS and SCHIP in order to gather additional information, such as identifying barriers to satisfaction, which would lead to recommendations for DMAS, MCOs, and/or providers. The EQRO may propose an alternate method (other than mail-in survey) for gathering consumer ideas for improvements. The focus of the interview questions will be on one of the CAHPS composites from the previous year that were determined to need improvement. For both years, reports on the evaluation of customer satisfaction will be provided to DMAS.

Purpose: The 2008 calendar year will mark the completion of the most recent CAHPS survey, with the results reported in Quality Compass 2008. The customer satisfaction evaluation will enable the DMAS and the MCOs to identify trends in customer experience and identify opportunities for improvement. The purpose of the modified consumer satisfaction assessment is to gather input from enrollees on how the customer experience can be improved. The ideas gathered from participants will be synthesized by the EQRO and reported with actionable recommendations for improving the customer experience.

Methodology: Data collection should be completed by the end of the second quarter of each calendar year 2009 and 2011. For calendar years 2009 and 2011, the EQRO will design, administer, and produce a report for a CAHPS-like survey (or other approved methodology for gathering consumer input).

Analysis and Reporting: The EQRO shall produce an annual customer satisfaction report on a specific CAHPS composite needing improvement that includes: 1) an executive summary not to exceed 2-3 pages; 2) description of methods of data collection and analysis 3) summarized assessment of consumer input; and 5) Recommendations for actionable next steps toward improving the composite score.

Correspondence: The Contractor shall engage DMAS in on-going communication regarding methodology and data needs.

Deliverables: At the conclusion of the study, a draft report of study results will be submitted, and a final report will be delivered, after the Department has reviewed and commented on the draft report. The annual customer satisfaction final report is due to DMAS by October 1, 2009 and October 1, 2011.

R-Task O. PACE Site Compliance Review

Based on the federal regulations, the PACE sites are required to meet quality standards. In order to assist the PACE sites with meeting the standards, the EQRO shall conduct an assessment to ascertain the effectiveness of the data collection methods and processes that each site is using to meet the CMS requirements.

The EQRO shall conduct the compliance review on each PACE site (six sites throughout Virginia) during the 2010 calendar year. For the elements that are determined to either be partially met or not met, the EQRO will conduct a follow-up assessment (either onsite or desk review, whichever is most efficient and effective) for each site nine months following the initial review.

Task: The Contractor shall perform an onsite assessment of each PACE site to measure the adherence to federal requirements for data collection that is relevant to the CMS mandated quality assurance requirements. See Attachment G for the elements that the EQRO would use to guide its assessment of each PACE site.

Purpose: To assess the level of progress the PACE sites are making on their federally mandated quality assurance requirements and identify opportunities for improvement.

Methodology: The onsite review will take place during the 2010 calendar year and the follow-up assessment will take place nine months following the initial review. The Contractor shall conduct the initial assessment during a one or two day onsite meeting at an office of each PACE site. At least six weeks prior to the onsite meeting, each PACE site primary contact will receive, from the Contractor, a list (approved by DMAS) of specific documentation and/or subject matter experts that will need to be available to the Contractor during the onsite assessment.

Analysis and Reporting: The EQRO shall prepare a memo to DMAS within 30 working days after the onsite review that outlines the elements that were reviewed and the level of compliance with each. The EQRO shall clearly define any deficiencies that were identified. This rapid-cycle feedback is imperative to enable DMAS to intervene with any PACE site that needs to adjust data collection methods or improve process in order to be in compliance with federal requirements. The EQRO shall also produce an aggregate report that delineates common strengths, weaknesses, and opportunities for improvement with regards to the PACE sites and the progress they are making toward CMS requirements for quality assurance.

Correspondence: Contractor will coordinate scheduling the assessments with each PACE site directly. The EQRO must engage the PACE sites and DMAS in the review of preliminary findings and draft reports.

Deliverables: The onsite assessment will be completed and reported to DMAS no later than thirty working days after each onsite assessment. All memos (and the aggregate report) must be reviewed and finalized by June 30, 2010. The nine month follow-up assessments must be completed, reviewed, and reported no later than April 1, 2011.

R-Task P. Independent Review of FAMIS Appeals

Task: The Contractor shall conduct the final review of adverse actions by a MCO providing services to FAMIS enrollees.

Purpose: To determine, after reviewing all relevant medical and contractual information, and advise the Director by a written determination, as to whether the service was or was not medically necessary.

Methodology: A review to assess the decision to deny payment for a particular medical service, in whole or part, or deny a required preauthorization pursuant to 12 VAC 30-141-40-D and E, which states:

Review of an adverse action made by the MCHIP [Mangaged Care Health Insurance Plan] *must be conducted by a person or agent of the MCHIP who has not been directly involved in the adverse action under review. After final review by the MCHIP, there*

shall also be opportunity for final independent external review by the external quality review organization.

Correspondence: DMAS and the Contractor and the MCOs.

Analysis and Reporting: The written determination shall state the specific factual basis for the expert reviewer's determination, including the clinical basis for the determination and the source of the criteria or interpretive guidelines utilized. In addition, the written determination shall include a description of the qualifications of the expert reviewer, and a certification by the contractor that the contractor and the expert reviewer have no material conflicts of interest that may affect the impartiality of the external review process and determination. The expert reviewer must also be able to testify as an expert witness, if necessary.

Deliverables: As appeals are filed by the Department the contractor shall submit the written determination to the Director within 45 days of receipt of the information necessary to conduct the review for regular reviews. For expedited reviews, the Contractor shall submit the written determination to the Director within 48 hours of receipt of the information necessary to conduct the reviews. Time extensions will be granted only for excusable delays that arise from unforeseeable causes beyond the control and without the fault or negligence of the Contractor.

Note: *The Offeror should cost this task per appeal, understanding that over the course of the past six years, there have been six independent reviews conducted by an EQRO. The volume is not expected to increase, therefore during a given year, the quantity is expected to range from an estimate of zero to six.*

V. Data Collection/ Management

The Contractor shall receive complete data files in SAS or delimited format via secure file transfer at the beginning of each contract year with a refresh of the enrollment, administrative, and encounter data every six months to conduct administrative (claims and encounters) data analysis in all studies. During the project start-up period (Oct 1-Nov 30, 2008) at least one meeting will include an overview of the Department's data system.

VI. Transition or Termination Management

The Contractor shall coordinate with the Department's current EQRO vendor and each of the Department's contracted MCOs to implement a smooth transition of EQR duties. It will be the Contractor's responsibility to include with its response to the RFP how it plans to work with all affected parties in the transition to a new reporting schedule.
At the expiration of this Contract, or if at any time the Department desires a transition of all or any part of the duties and obligations of Contractor to the Department or to another vendor, such notice shall be provided at least sixty (60) calendar days prior to the date the Contract will expire, or at the time the Department provides notice of

termination to Contractor, as the case may be. The transition process will commence immediately upon such notification and shall, at no additional cost to the Department, continue past the date of contract termination or expiration if, due to the actions or inactions of Contractor, the transition process is not completed before that date.

If delays in the transition process are due to the actions or inactions of the Department or the Department's newly designated vendor, the Department and Contractor will negotiate in good faith a contract for the conduct of and compensation for transition activities after the termination or expiration of the Contract. In the event that a subsequent Contractor is unable to assume operations on the planned date for transfer, the Contractor will continue to perform operations on a month-to-month basis for up to six months beyond the planned transfer date. The Department will withhold final payment to the Contractor until transition to the new Contractor is complete. Additionally, any data used or generated in the course of the studies by the Contractor or its sub-contractors, in any format, re-formatted or re-coded, is the property of the Department. All such data files shall be submitted to the Department at the conclusion of each study or upon request.

VII. Confidentiality – Use of Data

The Contractor and all contract staff shall maintain the confidentiality of all data that was received and analyzed during the external quality review process in accordance with HIPAA standards.

A. Security

The Contractor acknowledges that ownership of any data provided by DMAS remains with DMAS and agrees to: a) return the data to DMAS at the conclusion of each item listed in the Statement of Needs; b) use the data only for the activities described in the Statement of Needs and for no other purpose unless the Contractor first obtains written permission from DMAS; c) ensure that access to the data will be limited to direct employees actively engaged in this project; and, d) follow federal and state confidentiality requirements as set forth in the Code of Federal Regulations and pursuant to the Code of Virginia.
The Contractor shall also comply with all HIPAA standards.

B. Confidentiality of DMAS' Safety and Security Systems and Vulnerabilities

Contractor agrees to observe complete confidentiality with respect to all aspects of any confidential information, proprietary data and/or trade secrets and any parts thereof, whether such contents are the Department's or other manufacturer, contractor, or distributor whereby Contractor or any of Contractor's personnel may gain access while engaged by the Department or while on Department's, or any of the Department's agents or other contractor's premises. Revealing, copying or using in any manner whatsoever any such contents which have not been authorized by the Department are strictly prohibited. The restrictions herein shall survive the termination of this Contract

for any reason and shall continue in full force and effect and shall be binding upon Contractor, his agents, employees, successors, assigns, subcontractor's agent, employees, successors, assigns and subcontractors of the restrictions, present and continuing, set forth herein. Contractor shall defend and incur all costs, if any, for actions which arise as a result of non-compliance by Contractor, its agents, employees, successors, assigns and subcontractors regarding the restrictions herein.

VIII. PROPOSAL PREPARATION AND SUBMISSION REQUIREMENTS

Each Offeror shall submit a separate Technical Proposal and a Cost Proposal in relation to the requirements described in this RFP. The following describes the general requirements and the specific requirements for the Technical Proposal and the Cost Proposal.

General Requirements for Technical Proposals and Cost Proposals

8.1. Overview

Both the Technical Proposal and the Cost Proposal shall be developed and submitted in accordance with the instructions outlined in this section. The Offeror's proposals shall be prepared simply and economically, and they shall include a straightforward, concise description of the Offeror's capabilities that satisfy the requirements of the RFP. The Cost Proposal must also clearly delineate associated costs for each task. The Offeror should separate the costs for administrative data analysis and the costs for medical record abstraction for each focused study.

Although concise, the proposals should be thorough and detailed so that DMAS may properly evaluate the Offeror's capacity to provide the required services. All descriptions of services should include an explanation of proposed methodology, where applicable. The proposals may include additional information that the Offeror considers relevant to this RFP.

The proposals shall be organized in the order specified in this RFP. A proposal that is not organized in this manner risks elimination from consideration if the evaluators, at their sole discretion, are unable to find where the RFP requirements are specifically addressed. Failure to provide information required by this RFP may result in rejection of the proposal. The following schedule outlines the RFP milestones, which are subject to change:

- Post and advertise RFP 6/20/08-6/26/08
- Receive questions from potential Offerors And letters of intent due 7/10/08
- Post answers to questions 7/21/08
- Proposals due 8/13/08
- Select and negotiate Through 9/12/08
- Post Notice of Intent to Award Through 9/22/08

- Sign contract 10/01/08
- 1st day of EQRO scope of work 11/01/08

8.1.1 Critical Elements of the Technical Proposal

The Offeror must cross reference its Technical proposal with each requirement listed in Section IV of this RFP. In addition, the Offeror must assure that the following documentation is included in the proposal for each task:

- Who (type of expertise) will accomplish the activities and milestones associated with each task;
- What the outputs of the task will be;
- When each tasks specific milestones will be accomplished;
- How each milestone and/or associated activities will be planned and implemented (i.e. data collection, analysis plan, etc).

The Offeror must also describe how it will manage, monitor, and track its performance as an EQRO for the Contractor. The Offeror shall describe how it will identify opportunities for improvement, define actionable steps for improvement, and continuously track its performance as an EQRO for the Contractor.

8.2 Binding of Proposal

The Technical Proposal shall be clearly labeled “Technical Proposal” on the front cover. The Cost Proposal shall be clearly labeled “Cost Proposal” on the front cover. The legal name of the organization submitting the proposal shall also appear on the covers of both the Technical Proposal and the Cost Proposal.

The proposals shall be typed, bound, numbered, single-spaced with a 12-point font on 8 1/2” x 11” paper with 1” margins and printed on one side only. Each copy of the Technical Proposal and each copy of the Cost Proposal and all documentation submitted shall be contained in single three-ring binder volumes. A tab sheet keyed to the Table of Contents shall separate each major section. The title of each major section shall appear on the tab sheet.

The Offeror shall submit an original and ten (10) copies of the Technical Proposal and one original of the Cost Proposal by the response date and time specified in this RFP. Each copy of the proposal shall be bound separately. This submission shall be in a sealed envelope or sealed box clearly marked “RFP 2008-05 Technical Proposal”. In addition, the original of the Cost Proposal shall be sealed separately and clearly marked “RFP 2008-05 Cost Proposal” and submitted by the response date and time specified in this RFP. The Cost Proposal form in Attachment C shall be used. The Offeror shall also submit one electronic copy (compact disc preferred) of their Technical Proposal in MS Word format (Microsoft Word 2000 or compatible format) and of their Cost Proposal in MS Excel format (Microsoft Word 2000 or compatible format). In addition, the Offeror shall submit a redacted (proprietary and confidential information removed) electronic copy in PDF format of their Technical Proposal and their Cost Proposal.

8.3 Table of Contents

The proposals shall contain a Table of Contents that cross-references the RFP submittal requirements in Section 4: “Technical Proposal Requirements.” Each section of the Technical Proposal shall be cross-referenced to the appropriate section of the RFP that is being addressed. This will assist DMAS in determining uniform compliance with specific RFP requirements.

8.4 Submission Requirements

All information requested in this RFP shall be submitted in the Offeror’s proposal. A Technical Proposal shall be submitted and a Cost Proposal shall be submitted in the Offeror’s collective response. The proposals will be evaluated separately. By submitting a proposal in response to this RFP, the Offeror certifies that all of the information provided is true and accurate.

All data, materials and documentation originated and prepared for the Commonwealth pursuant to this RFP belong exclusively to the Commonwealth and shall be subject to public inspection in accordance with the Virginia Freedom of Information Act. Confidential information shall be clearly marked in the proposal and reasons the information should be confidential shall be clearly stated.

The Commonwealth agrees that neither it nor its employees, representatives, or agents shall knowingly divulge any proprietary information with respect to the operation of the software, the technology embodied therein, or any other trade secret or proprietary information related thereto, except as specifically authorized by the Contractor in writing or as required by the Freedom of Information Act or similar law. It shall be the Contractor’s responsibility to fully comply with § 2.2-4342F of the Code of Virginia. All trade secrets or proprietary information must be identified in writing or other tangible form and conspicuously labeled as “proprietary” either prior to or at the time of submission to the Commonwealth.

The Contractor assures that information and data obtained as to personal facts and circumstances related to patients or clients shall be collected and held confidential, during and following the term of this agreement, and will not be divulged without the individual’s and the agency’s written consent. Any information to be disclosed, except to the agency, must be in summary, statistical, or other form which does not identify particular individuals. Contractors and their employees working on this project shall be required to sign the Confidentiality Statement in this solicitation.

Ownership of all data, materials, and documentation originated and prepared for the State pursuant to the RFP shall belong exclusively to the State and be subject to public inspection in accordance with the Virginia Freedom of Information Act. Trade secrets or proprietary information submitted by an Offeror shall not be subject to public disclosure under the Virginia Freedom of Information Act; however, the Offeror must invoke the protections of § 2.2-4342F of the Code of Virginia, in writing, either before or at the time

the data or other material is submitted. The written notice must specifically identify the data or materials to be protected and State the reasons why protection is necessary. The proprietary or trade secret materials submitted must be identified by some distinct method such as highlighting or underlining and shall indicate only the specific words, figures, or paragraphs that constitute trade secret or proprietary information. The classification of an entire proposal document, line item prices and/or total proposal prices as proprietary or trade secrets is not acceptable and, in the sole discretion of DMAS, may result in rejection and return of the proposal.

All information requested by this RFP on ownership, utilization and planned involvement of small businesses, small-women-owned businesses and small-minority-owned business shall be submitted with the Technical Proposal.

8.5 Transmittal Letter

The transmittal letter shall be on official organization letterhead and signed by the individual authorized to legally bind the Offeror to contract agreements and the terms and conditions contained in this RFP. The organization official who signs the proposal transmittal letter shall be the same person who signs the cover page of the RFP and Addenda.

At a minimum, the transmittal letter shall contain the following:

1. A Statement that the Offeror meets the required conditions to be an eligible candidate for the contract award including:
   a) The Offeror must identify any contracts or agreements they have with any State or local government entity that is a Medicaid and/or Title XXI State Child Health Insurance Program provider or Contractor and the general circumstances of the contract or agreement. This information will be reviewed by DMAS to ensure there are no potential conflicts of interest;
   b) Offeror must be able to present sufficient assurances to the State that the award of the contract to the Offeror will not create a conflict of interest between the Contractor, the Department, and its subcontractors; and
   c) The Offeror must be licensed to conduct business in the State of Virginia.
2. A Statement that the Offeror has read, understands and agrees to perform all of the Contractor responsibilities and comply with all of the requirements and terms set forth in this RFP, any modifications of this RFP, the Contract and Addenda;
3. The Offeror's general information, including the address, telephone number, and facsimile transmission number;
4. Designation of an individual as the authorized representative of the organization who will interact with DMAS on any matters pertaining to this RFP and the resultant Contract; and
5. A Statement agreeing that the Offeror's proposal shall be valid for a minimum of 180 days from its submission to DMAS.

8.6 Signed Cover Page of the RFP and Addenda

To attest to all RFP terms and conditions, the authorized representative of the Offeror shall sign the cover page of this RFP, as well as the cover page of the Addenda, if issued, to the RFP, and submit them along with its proposal.

8.7 Principal Point of Contact

The principal point of contact for this procurement in DMAS shall be:

Carol Stanley
Disease Management and Quality Improvement Analyst
Healthcare Services Division
Virginia Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, VA 23219
E-mail: EQRO@dmas.virginia.gov

All communications with DMAS regarding this RFP should be directed to the principal point of contact. All RFP content-related questions shall be in writing to the principal point of contact or the DMAS' Contract Management Officer. An Offeror who communicates with any other employees or Contractors of DMAS concerning this RFP after issuance of the RFP may be disqualified from this procurement.

8.8 Submission and Acceptance of Proposals

The proposals, whether mailed or hand delivered, shall arrive at DMAS no later than 2:00 p.m. local time on August 13, 2008. DMAS shall be the sole determining party in establishing the time of arrival of proposals. Late proposals shall not be accepted and shall be automatically rejected from further consideration. It is the Offerors responsibility to ensure that proposals are received prior to the due date and time, regardless of the delivery method. The address for delivery is:

Proposals may be sent by US mail, Federal Express, UPS, etc. to:
Attention: William Sydnor
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, VA 23219

Hand Delivery or Courier to:
Attention: William Sydnor
Department of Medical Assistance Services
7th Floor DMAS' Receptionist
600 East Broad Street
Richmond, VA 23219

If DMAS does not receive at least one responsive proposal as a result of this RFP, DMAS reserves the right to select a Contractor that best meets DMAS' needs. DMAS management shall select this Contractor. DMAS also reserves the right to reject all proposals. DMAS reserves the right to delay implementation of the RFP if a satisfactory Contractor is not identified or if DMAS determines a delay is necessary to ensure implementation goes smoothly without service interruption. Information and addendum to this RFP will be posted on the DMAS' web site, http://www.dmas.virginia.gov and http://www.eva.virginia.gov/

8.9 Oral Presentation and Site Visit

DMAS may require one or more oral presentations by an Offeror in response to questions DMAS has about the Offeror's proposal. An oral presentation means that the Offeror is either physically present in a DMAS designated meeting room or participating via conference call, per DMAS' preference. DMAS will allow a minimum five-business day advance notice to the Offeror prior to the date of the oral presentation. Expenses incurred as part of the oral presentation shall be the Offeror's responsibility.

DMAS may make one or more on-site visits to see the Offeror's operation of another contract, both Medicaid and non-Medicaid. DMAS shall be solely responsible for its own expenses for travel, food and lodging.

8.10 Technical Proposal

The following describes the required format, content and sequence of presentations for the Technical Proposal:

8.10.1 Chapter One: Executive Summary

The Executive Summary Chapter shall highlight the Offeror's:

1. Understanding of the EQR requirements.
2. Qualifications to serve as the DMAS' Contractor for the project.
3. Overall Approach to meeting the objectives and a summary of the contents of the proposal.

8.10.2 Chapter Two: Corporate Qualifications and Experience

Chapter Two shall present the Offeror's qualifications and experience to serve as the Contractor. Specifically, the Offeror shall describe its:

1. Organization Status:
    a) Name of Project Director for this Contract;
    b) Name, address, telephone number, fax number, and e-mail address of the legal entity with whom the contract is to be written;
    c) Federal employer ID number;

d) Name, address, telephone numbers of principal officers (president, vice-president, treasurer, chair of the board of directors, and other executive officers);
e) Name of the parent organization;
f) Major business services;
g) QIO certification;
h) Legal status and whether it is a for-profit or a not-for-profit company;
i) A list of board members and their organizational affiliations; and
j) Any specific licenses and accreditation held by the Offeror.

2. Corporate Experience; the Offeror shall clearly delineate: if it has an EQRO business partner, and whether the Offeror, the business partner, or both meet the following:
   a) Offeror's overall qualifications to carry out a project of this nature and scope.
   b) The Offeror shall describe the background and success of the Offeror's organization and experience in performing external quality review services.
   c) The Offeror's knowledge of the Medicaid and/or SCHIP recipient populations and the communities.
   d) For each experience with external quality review services, the Offeror shall indicate the contract or project title, dates of performance, scope and complexity of contract, and customer references (see below). The Offeror shall also include in its description of the scope of each contract, the CMS-mandated activities that it performed and the optional EQR activities that were performed.
   e) Any other related experience the Offeror feels is relevant shall be included.
   f) The Offeror shall indicate whether the Offeror has had a contract terminated for any reason within the last five years.
   g) The Offeror also shall indicate if a claim was made on a payment or performance bond. If so, the Offeror shall submit full details of the termination and the bonds including the other party's name, address, and telephone number.

3. References and Evidence of Capabilities of the Offeror and/or its EQRO business partner. If the Offeror is responding to the RFP in partnership with an EQRO business partner, all of the following questions must be answered for both the Offeror and its business partner.
   a) Two State agency customers who will substantiate the Offeror's (or its business partners) qualifications and capabilities to perform the services required by the RFP.
   b) Two customers who can attest to the Offeror's experience with interface files for data loads.
   c) Contact information for all external quality review contracts for Medicaid, Medicare or SCHIP products and any Virginia based non-Medicaid groups

the Offeror chooses to include, held by the Offeror at any time since January 1, 2002.

d) Three samples of healthcare quality publications that the Offeror has developed and that have been published in the public domain (state or federal government agency website, for example) for use by program and/or policy makers. DMAS is looking for evidence of customer satisfaction in the Offeror's outputs and style of presenting reports.

The Offeror shall complete the Reference Form in Attachment E for each reference and contract, which includes the contract name, address, telephone number, contact person, and periods of work performance.

4. Financial Stability:

The Offeror shall submit evidence of financial stability for itself and its EQRO business partner, if applicable. The Offeror should submit one of the following financial reports:

1) For a publicly held corporation, a copy of the most recent three years of audited financial reports and financial statements with the name, address, and telephone number of a responsible person in the Offeror's principal financial or banking organization, or
2) For a privately held corporation, proprietorship, or partnership, financial information for the past three years, similar to that included in an annual report, to include, at a minimum, an income statement, a statement of cash flows, a balance sheet, and number of years in business, as well as the name, address, and telephone number of a contact in the Offeror's principal financial or banking organization and its auditor.

8.10.3 Chapter Three: Tasks and Technical Approach

The Offeror shall fully describe how it intends to meet all of the tasks required in Section 3 of the RFP and technical proposal requirements listed in Section 4 of this RFP. DMAS does not want a "re-write" of the RFP requirements. Specifically, the Offeror shall describe in detail its proposed approach for each of the required and optional tasks listed in Section 3 and technical proposal requirements in Section 4 including any staff, systems, procedures, or materials that will be used to perform these tasks. This includes how each task will be performed, what problems need to be overcome, what functions the staff will perform, and what assistance will be needed from DMAS, if any.

Note: DMAS welcomes new and innovative approaches to EQR services. While fully addressing the objectives in the RFP, the Offeror may also include alternate approaches for DMAS' consideration. DMAS welcomes ideas for efficiencies and economies of scale with regards to the timing of and the milestones for the required

and optional tasks in order to reduce administrative burdens and costs to DMAS, the EQRO, and/or MCOs.

8.10.4 Chapter Four: Staffing

The proposal shall describe the following:

1. Staffing Plan: The Offeror shall provide a functional organizational chart of the proposed project structure and organization, indicating the lines of authority for proposed staff directly involved in performance of this contract and relationships of the staff to each function of the organization. The staffing plan shall indicate the number of proposed FTEs by position and an estimate of hours to be committed to the project by each staff position. The plan shall also show the number of staff to be employed by the Contractor and staff to be obtained through subcontracting arrangements. The Offeror shall also describe its process for being able to fill positions when they become vacant and how it will ensure that the progress of tasks will not be interrupted should there be any staffing changes throughout the duration of the contract. The staffing plan for the EQRO must include (but not be limited to)key staff: a project director/manager who will be the primary FTE that is dedicated to managing the contract with DMAS; a medical director who dedicates a portion of their time to the clinical accuracy of the deliverables; a Ph.D. level statistician who dedicates a portion of their time to leading sound and methodical statistical analysis of tasks; and a communications professional who is able to synthesize technical information into reports that are accurate, aesthetically pleasing, and understandable to program and policy planners. The Offeror should describe how it will maintain the proposed level of staffing throughout the life of the contract. Failure to maintain the proposed level of staffing could result in termination of the contract.

2. Staff Qualifications and Resumes: Job descriptions for all key staff on the project including qualifications, experience and/or expertise required should be included. Resumes limited to two pages must be included for key staff. The resumes of personnel proposed must include qualifications, experience, and relevant education, professional certifications and training for the position they will fill.

3. Office Location: A description of the geographical location of the central business office, the billing office and satellite offices, if applicable, shall be included. In addition, the hours of operation should be noted for each office as applicable to this contract. The Offeror must include its capabilities, willingness, and commitment toward responding favorably to the needs and requests for traveling to locations throughout Virginia as needed.

8.10.5 Chapter Six: Project Work Plan

The proposal shall describe the following:

A three-year Work Plan: The proposal shall include a work plan (Microsoft Project 2000 or compatible version) detailing the sequence of events and the time required to plan and implement each task. The relationship between key staff and the specific tasks and assignments proposed to accomplish the scope of work shall also be included. A PERT, Gantt, or Bar Chart that clearly outlines the EQR task timetable from beginning to end shall be included in the proposal. Key dates (e.g. final reports) and key events (e.g. data collection) relative to the project shall be clearly described on the chart including critical path of tasks. The Offeror shall describe its analysis approach and how its proposed work plan will be executed. The Offeror must provide and maintain sufficient physical, technological, and financial resources to conduct an EQR. The Offeror must also describe how it will monitor the quality of its work processes, services, and products that it provides as part of the EQR contract.

Progress Reports: Upon award of a contract, the Contractor must prepare a written progress report by the 10th of each month or more frequently as necessary and present this report to the Quality Analyst or a designee. The report must be in a DMAS-approved format. The report must include:

1. Status of major activities and tasks in relation to the Contractor's work plan, including specific tasks completed for each part of the project.
2. Target dates for completion of remaining or upcoming tasks/activities.
3. Any potential delays or problems anticipated or encountered in reaching target dates and the reason for such delays.
4. Any revisions to the overall work schedule.
5. The Offeror must also acknowledge that DMAS intends to conduct at least one onsite review each year at the Offeror's main office to meet with relevant staff, review operations and review contract management processes that directly relate to the contract. The DMAS does not intend to infringe on any proprietary business practices during the reviews.

If it becomes necessary to revise any part of this RFP, or if additional data is necessary for an interpretation of provisions of this RFP prior to the due date for proposals, an addendum will be issued to all Offerors by the Department. If supplemental releases are necessary, the Department reserves the right to extend the due dates and time for receipt of proposals to accommodate such interpretations of additional data requirements. The RFP and subsequent information will be listed on the Department's website http://www.dmas.virginia.gov and http://www.eva.virginia.gov/ .

IX. PROPOSAL EVALUATIONS AND AWARD CRITERIA

DMAS will conduct a comprehensive, fair, and impartial evaluation of the Technical and Cost Proposals received in response to this RFP. The Evaluation Team will be

responsible for the review and scoring of all proposals. This group will be responsible for the recommendation to the DMAS' Director.

9.1 Evaluation of Minimum Requirements

DMAS will initially determine if each proposal addresses the minimum RFP requirements to permit a complete evaluation of the Technical and Cost Proposals. Proposals shall comply with the instructions to Offerors contained throughout this RFP. Failure to comply with the instructions shall result in a lower scoring of the proposal. DMAS reserves the right to waive minor irregularities.

The minimum requirements for a proposal to be given consideration are:

RFP Cover Sheet: This form shall be completed and properly signed by the authorized representative of the organization.

Closing Date: The proposal shall have been received, as provided in Section 8.8, before the closing of acceptance of proposals in the number of copies specified.

Compliance: The proposal shall comply with the entire format requirements described in Section 4 and the Technical Proposal and Cost Proposal requirements described in Section 8.

Mandatory Conditions: All mandatory General and Specific Terms and Conditions contained in Sections 10 and 11 shall be accepted.

9.2 Proposal Evaluation Criteria

Note: Optional tasks will not be included in the scoring of the Offeror's proposal, however, the Offeror should include the optional tasks in its proposal.

The broad criteria for evaluating proposals include the six elements listed below:

1. Experience		**20%**
	Experience of the Offeror and/or its EQRO business partner in performing EQR services for Medicaid and for SCHIP	
	Experience of the Offeror and/or its EQRO business partner in conducting studies that are designed to aid planners and policy makers in reducing health/healthcare disparities among underserved populations	
	Experience of Offeror and/or its business partner in the Commonwealth of Virginia or other state(s) with similar Medicaid and/or SCHIP programs and delivery systems	
	Experience of Offeror and/or its business partner in	

	performing services within the past year(s) most comparable to the Offeror's proposal, to include a description of the type, size, and duration of previous experience	
	Experience of the Offeror and/or its business partner in producing quality reports that are written for the customer and their key stakeholders. Samples of reports will be included.	
2. Technical Proposal		**35%**
	Demonstration in the written proposal of the Offeror's ability, facilities and capacity to provide all required services in a timely, efficient and professional manner.	
	Clarity and thoroughness of the Offeror's proposal in addressing the components of the RFP and implementing them as described and on schedule.	
	A clearly delineated three-year work plan.- task timelines, key staff, milestones, on-going communications with DMAS and other key stakeholders, and other elements that the Offeror considers important for having a three-year work plan.	
	Proposed project management of the resources available to the Offeror for meeting the requirements of the RFP.	
	Innovation and comprehensive knowledge of current health quality and Medicaid evaluation trends.	
3. Staffing		**10%**
	Describe the experience and expertise of specific staff assigned to the contract.	
	Assurance that the proposed staffing level will exist throughout the life of the contract.	
	Prior experience of staff with similar projects.	
	Qualifications of staff.	
	Appropriateness of the relationship between staff qualifications and assigned responsibilities.	
4. Quality of References		**5%**
	References who clearly address the nature of the work performed by the Offeror.	
	References who exhibit satisfaction with the work performed by the Offeror.	
	Contacts for other contracts who exhibit satisfaction with the offeror.	
5. SWAM Requirements		**20%**

	Small business utilization plan	
6. Cost		**10%**

Award

Selection shall be made of one or two Offerors deemed to be fully qualified and best suited among those submitting proposals on the basis of the evaluation factors included in the Request for Proposals, including price, if so stated in the Request for Proposals. Negotiations shall be conducted with the Offeror(s) so selected. Price shall be considered, but need not be the sole determining factor. After negotiations have been conducted with each Offeror so selected, the agency shall select the Offeror which, in its opinion, has made the best proposal, and shall award the contract to that Offeror. The Commonwealth may cancel this Request for Proposals or reject proposals at any time prior to an award, and is not required to furnish a statement of the reasons why a particular proposal was not deemed to be the most advantageous (Code of Virginia, § 2.2-4359D). Should the Commonwealth determine in writing and in its sole discretion that only one Offeror is fully qualified, or that one Offeror is clearly more highly qualified than the others under consideration, a contract may be negotiated and awarded to that Offeror. The award document will be a contract incorporating by reference all the requirements, terms and conditions of the solicitation and the contractor's proposal as negotiated.

9.3 Best and Final Offer

At the conclusion of negotiations, the Offeror(s) may be asked to submit in writing, a Best and Final Offer (BAFO). After the BAFO is submitted, no further negotiations shall be conducted with the Offeror(s). The Offeror's proposal will be rescored to combine and include the information contained in the BAFO. The decision to award will be based on the final evaluation including the BAFO.

X. GENERAL TERMS AND CONDITIONS

10.1 Vendors Manual

This solicitation is subject to the provisions of the Commonwealth of Virginia Vendors Manual and any changes or revisions thereto, which are hereby incorporated into this contract in their entirety. The procedure for filing contractual claims is in section 7.19 of the Vendors Manual. A copy of the manual is normally available for review at the purchasing office and is accessible on the Internet at www.dgs.State.va.us/dps under "Manuals."

10.2 Applicable Laws and Courts

This solicitation and any resulting contract shall be governed in all respects by the laws of the Commonwealth of Virginia and any litigation with respect thereto shall be brought in the courts of the Commonwealth. The Department and the Contractor are

encouraged to resolve any issues in controversy arising from the award of the contract or any contractual dispute using Alternative Dispute Resolution (ADR) procedures (Code of Virginia, §2.2-4366). ADR procedures are described in Chapter 9 of the Vendors Manual. The Contractor shall comply with all applicable federal, State and local laws, rules and regulations.

10.3 Anti-Discrimination

By submitting their proposals, Offerors certify to the Commonwealth that they shall conform to the provisions of the Federal Civil Rights Act of 1964, as amended, as well as the Virginia Fair Employment Contracting Act of 1975, as amended, where applicable, the Virginians With Disabilities Act, the Americans With Disabilities Act and §2.2-4311 of the Virginia Public Procurement Act (VPPA), and any other applicable laws. If the award is made to a faith-based organization, the organization shall not discriminate against any recipient of goods, services, or disbursements made pursuant to the contract on the basis of the recipient's religion, religious belief, refusal to participate in a religious practice, or on the basis of race, age, color, gender or national origin and shall be subject to the same rules as other organizations that contract with public bodies to account for the use of the funds provided; however, if the faith-based organization segregates public funds into separate accounts, only the accounts and programs funded with public funds shall be subject to audit by the public body. (Code of Virginia, § 2.2-4343.1E).

In every contract over $10,000, the provisions in Sections 9.3.1 and 9.3.2. below apply:

10.3.1. During the performance of this contract, the Contractor agrees as follows:

a) The Contractor shall not discriminate against any employee or applicant for employment because of race, religion, color, sex, national origin, age, disability, or any other basis prohibited by State law relating to discrimination in employment, except where there is a bona fide occupational qualification reasonably necessary to the normal operation of the Contractor. The Contractor agrees to post in conspicuous places, available to employees and applicants for employment, notices setting forth the provisions of this nondiscrimination clause.

b) The Contractor, in all solicitations or advertisements for employees placed by or on behalf of the Contractor, shall State that such Contractor is an equal opportunity employer.

c) Notices, advertisements and solicitations placed in accordance with federal law, rule or regulation shall be deemed sufficient for the purpose of meeting these requirements.

10.3.2. The Contractor shall include the provisions of 9.3.1 above in every subcontract or purchase order over $10,000, so that the provisions will be binding upon each subcontractor or Contractor.

10.4 Ethics in Public Contracting

By submitting their proposals, Offerors certify that their proposals are made without collusion or fraud and that they have not offered or received any kickbacks or inducements from any other Offeror, supplier, manufacturer or subcontractor in connection with their proposal, and that they have not conferred on any public employee having official responsibility for this procurement transaction any payment, loan, subscription, advance, deposit of money, services or anything of more than nominal value, present or promised, unless consideration of substantially equal or greater value was exchanged.

10.5 Immigration Reform and Control Act Of 1986

By submitting their proposals, Offerors certify that they do not and shall not during the performance of this contract employ illegal alien workers or otherwise violate the provisions of the federal Immigration Reform and Control Act of 1986.

10.6 Debarment Status

By submitting their proposals, Offerors certify that they are not currently debarred by the Commonwealth of Virginia or any other federal, State or local government from submitting bids or proposals on any type of contract, nor are they an agent of any person or entity that is currently so debarred.

10.7 Antitrust

By entering into a contract, the Contractor conveys, sells, assigns, and transfers to the Commonwealth of Virginia all rights, title and interest in and to all causes of action it may now have or hereafter acquire under the antitrust laws of the United States and the Commonwealth of Virginia, relating to the particular goods or services purchased or acquired by the Commonwealth of Virginia under said contract.

10.8 Mandatory Use of State Form and Terms and Conditions

Failure to submit a proposal on the official State form, in this case the completed and signed RFP Cover Sheet, may be a cause for rejection of the proposal. Modification of or additions to the General Terms and Conditions of the solicitation may be cause for rejection of the proposal; however, the Commonwealth reserves the right to decide, on a case by case basis, in its sole discretion, whether to reject such a proposal.

10.9 Clarification of Terms

If any prospective Offeror has questions about the specifications or other solicitation documents, the prospective Offeror should contact Carol Stanley Contract Monitor no

later than 2:00 pm on 06/10/2008. Any revisions to the solicitation will be made only by addendum issued by the buyer.

10.10 Payment

1. To Prime Contractor:

   a. Invoices for items ordered, delivered and accepted shall be submitted by the Contractor directly to the payment address shown on the purchase order/contract. All invoices shall show the State contract number and/or purchase order number; Social Security number (for individual Contractors) or the federal employer identification number (for proprietorships, partnerships, and corporations).
   b. Any payment terms requiring payment in less than 30 days will be regarded as requiring payment 30 days after invoice or delivery, whichever occurs last. This shall not affect offers of discounts for payment in less than 30 days, however.
   c. All goods or services provided under this contract or purchase order, that are to be paid for with public funds, shall be billed by the Contractor at the contract price, regardless of which public agency is being billed.
   d. The following shall be deemed to be the date of payment: the date of postmark in all cases where payment is made by mail, or the date of offset when offset proceedings have been instituted as authorized under the Virginia Debt Collection Act.
   e. Unreasonable Charges: Under certain emergency procurements and for most time and material purchases, final job costs cannot be accurately determined at the time orders are placed. In such cases, Contractors should be put on notice that final payment in full is contingent on a determination of reasonableness with respect to all invoiced charges. Charges that appear to be unreasonable will be researched and challenged, and that portion of the invoice held in abeyance until a settlement can be reached. Upon determining that invoiced charges are not reasonable, the Commonwealth shall promptly notify the Contractor, in writing, as to those charges which it considers unreasonable and the basis for the determination. A Contractor may not institute legal action unless a settlement cannot be reached within thirty (30) days of notification. The provisions of this section do not relieve the Department of its prompt payment obligations with respect to those charges that are not in dispute (Code of Virginia, § 2.2-4363).
   f. The Contractor shall invoice DMAS monthly for 75% of the 1/12 value of the total cost for the fiscal year. The Contractor may invoice DMAS for the remaining 25% of the monthly cost when the deliverables that are due for the invoice month are accepted by DMAS.

2. To Subcontractors:

a. A Contractor awarded a contract under this solicitation is hereby obligated:

(1) To pay the subcontractor(s) within seven (7) days of the Contractor's receipt of payment from the Commonwealth for the proportionate share of the payment received for work performed by the subcontractor(s) under the contract; or

1. To notify the Department and the subcontractor(s), in writing, of the Contractor's intention to withhold payment and the reason.

a. The Contractor is obligated to pay the subcontractor(s) interest at the rate of one percent per month (unless otherwise provided under the terms of the contract) on all amounts owed by the Contractor that remain unpaid seven (7) days following receipt of payment from the Commonwealth, except for amounts withheld as stated in (2) above. The date of mailing of any payment by U. S. Mail is deemed to be payment to the addressee. These provisions apply to each sub-tier Contractor performing under the primary contract. A Contractor's obligation to pay an interest charge to a subcontractor may not be construed to be an obligation of the Commonwealth.

3. Each prime Contractor who wins an award in which provision of a small business contracting plan is a condition to the award, shall deliver to the contracting Department or institution, on or before request for final payment, evidence and certification of compliance (subject only to insubstantial shortfalls and to shortfalls arising from subcontractor default) with the small business contracting plan. Final payment under the contract in question may be withheld until such certification is delivered and, if necessary, confirmed by the Department or institution, or other appropriate penalties may be assessed in lieu of withholding such payment.

10.11 Precedence of Terms

The following General Terms and Conditions: VENDORS MANUAL, APPLICABLE LAWS AND COURTS, ANTI-DISCRIMINATION, ETHICS IN PUBLIC CONTRACTING, IMMIGRATION REFORM AND CONTROL ACT OF 1986, DEBARMENT STATUS, ANTITRUST, MANDATORY USE OF STATE FORM AND TERMS AND CONDITIONS, CLARIFICATION OF TERMS, PAYMENT shall apply in all instances. In the event there is a conflict between any of the other General Terms and Conditions and any Special Terms and Conditions in this solicitation, the Special Terms and Conditions shall apply.

10.12 Qualifications of Offerors

a. The offer must be a qualified vendor that meets the requirements, as defined by federal regulations (42 CFR Part 475 *et seq*.), as a designated Quality Improvement Organization (QIO) formerly known as Peer Review Organization (PRO).

b. The Commonwealth may make such reasonable investigations as deemed proper and necessary to determine the ability of the Offeror to perform the services/furnish the goods and the Offeror shall furnish to the Commonwealth all such information and data for this purpose as may be requested. The Commonwealth reserves the right to inspect Offeror's physical facilities prior to award to satisfy questions regarding the Offeror's capabilities. The Commonwealth further reserves the right to reject any proposal if the evidence submitted by, or investigations of, such Offeror fails to satisfy the Commonwealth that such Offeror is properly qualified to carry out the obligations of the Contract and to provide the services and/or furnish the goods contemplated therein.

10.13 Testing And Inspection

The Commonwealth reserves the right to conduct any test/inspection it may deem advisable to ensure goods and services conform to the specifications.

10.14 Assignment of Contract

A contract shall not be assignable by the Contractor in whole or in part without the written consent of the Commonwealth. Any assignment made in violation of this section will be void.

10.15 Changes to the Contract

Changes can be made to the contract in any of the following ways:

1. The parties may agree in writing to modify the scope of the contract. An increase or decrease in the price of the contract resulting from such modification shall be agreed to by the parties as a part of their written agreement to modify the scope of the contract.
2. The Department may order changes within the general scope of the contract at any time by written notice to the Contractor. Changes within the scope of the contract include, but are not limited to, things such as services to be performed or are mandated by changes in federal or state laws or regulations. The Contractor shall comply with the notice upon receipt. The Contractor shall be compensated for any additional costs incurred as the result of such order and shall give the Department a credit for any savings. Said compensation shall be determined by one of the following methods:

a) By mutual agreement between the parties in writing; or

b) By agreeing upon a unit price or using a unit price set forth in the contract, if the work to be done can be expressed in units, and the Contractor accounts for the number of units of work performed, subject to the Department's right to audit the Contractor's records and/or to determine the correct number of units independently; or

c) By ordering the Contractor to proceed with the work and keep a record of all costs incurred and savings realized. A markup for overhead and profit may be allowed if provided by the contract. The same markup shall be used for determining a decrease in price as the result of savings realized. The Contractor shall present the Department with all vouchers and records of expenses incurred and savings realized. The Department shall have the right to audit the records of the Contractor as it deems necessary to determine costs or savings. Any claim for an adjustment in price under this provision must be asserted by written notice to the Department within thirty (30) days from the date of receipt of the written order from the Department. If the parties fail to agree on an amount of adjustment, the question of an increase or decrease in the contract price or time for performance shall be resolved in accordance with the procedures for resolving disputes provided by the Disputes Clause of this contract or, if there is none, in accordance with the dispute provisions of the Commonwealth of Virginia Vendors Manual. Neither the existence of a claim nor a dispute resolution process, litigation or any other provision of this contract shall excuse the Contractor from promptly complying with the changes ordered by the Department or with the performance of the contract generally.

10.16 Default

In case of failure to deliver goods or services in accordance with the contract terms and conditions, the Commonwealth, after due oral or written notice, may procure them from other sources and hold the Contractor responsible for any resulting additional purchase and administrative costs. This remedy shall be in addition to any other remedies, which the Commonwealth may have.

10.17 Insurance

By signing and submitting a bid or proposal under this solicitation, the Offeror certifies that if awarded the contract, it shall have the following insurance coverage at the time the contract is awarded. For construction contracts, if any subcontractors are involved, the subcontractor shall have workers' compensation insurance in accordance with §§ 2.2-4332 and 65.2-800 et seq. of the Code of Virginia. The Offeror further certifies that the Contractor and any subcontractors will maintain these insurance coverages during the entire term of the contract and that all insurance coverage will be provided by

insurance companies authorized to sell insurance in Virginia by the Virginia State Corporation Commission.

MINIMUM INSURANCE COVERAGES AND LIMITS REQUIRED FOR MOST CONTRACTS:

1. Workers' Compensation: Statutory requirements and benefits: Coverage is compulsory for employers of three or more employees to include the employer. Contractors who fail to notify the Commonwealth of increases in the number of employees that change their workers' compensation requirements under the Code of Virginia during the course of the contract shall be in noncompliance with the contract.
2. Employer's Liability: $100,000.
3. Commercial General Liability: $1,000,000 per occurrence. Commercial General Liability is to include bodily injury and property damage, personal injury and advertising injury, products and completed operations coverage. The Commonwealth of Virginia must be named as an additional insured and so endorsed on the policy.
4. Automobile Liability: $1,000,000 per occurrence. (Only used if motor vehicle is to be used in the contract.)
5. Professional Liability/Errors and Omission $1,000,000 per occurrence, $3,000,000 aggregate.

10.18 Announcement of Award

Upon the award or the announcement of the decision to award a contract over $50,000, as a result of this solicitation, the Department will publicly post such notice on the DGS/DPS eVA web site (www.eva.virginia.gov) for a minimum of 10 days.

10.19 Drug-Free Workplace

During the performance of this contract, the Contractor agrees to:

1. Provide a drug-free workplace for the Contractor's employees;
2. Post in conspicuous places, available to employees and applicants for employment, a statement notifying employees that the unlawful manufacture, sale, distribution, dispensation, possession, or use of a controlled substance or marijuana is prohibited in the Contractor's workplace and specifying the actions that will be taken against employees for violations of such prohibition;
3. State in all solicitations or advertisements for employees placed by or on behalf of the Contractor that the Contractor maintains a drug-free workplace; and
4. Include the provisions of the foregoing clauses in every subcontract or purchase order of over $10,000, so that the provisions will be binding upon each subcontractor or Contractor.

For the purposes of this section, “drug-free workplace” means a site for the performance of work done in connection with a specific contract awarded to a Contractor, the employees of whom are prohibited from engaging in the unlawful manufacture, sale, distribution, dispensation, possession or use of any controlled substance or marijuana during the performance of the contract.

10.20 Nondiscrimination of Contractors

A bidder, offeror, or contractor shall not be discriminated against in the solicitation or award of this contract because of race, religion, color, sex, national origin, age, disability, faith-based organizational status, any other basis prohibited by State law relating to discrimination in employment or because the bidder or Offeror employs ex-offenders unless the agency, department or institution has made a written determination that employing ex-offenders on the specific contract is not in its best interest. If the award of this contract is made to a faith-based organization and an individual, who applies for or receives goods, services, or disbursements provided pursuant to this contract objects to the religious character of the faith-based organization from which the individual receives or would receive the goods, services, or disbursements, the public body shall offer the individual, within a reasonable period of time after the date of his objection, access to equivalent goods, services, or disbursements from an alternative facility.

10.21 eVA Business-To-Government Vendor Registration

The eVA Internet electronic procurement solution, web site portal www.eVA.virginia.gov, streamlines and automates government purchasing activities in the Commonwealth. The eVA portal is the gateway for vendors to conduct business with State agencies and public bodies. All vendors desiring to provide goods and/or services to the Commonwealth shall participate in the eVA Internet e-procurement solution either through the eVA Basic Vendor Registration Service or eVA Premium Vendor Registration Service. All bidders or Offerors must register in eVA; failure to register will result in the bid/proposal being rejected.

a. eVA Basic Vendor Registration Service: $25 Annual Registration Fee plus the appropriate order Transaction Fee specified below. eVA Basic Vendor Registration Service includes electronic order receipt, vendor catalog posting, on-line registration, electronic bidding, and the ability to research historical procurement data available in the eVA purchase transaction data warehouse.

b. eVA Premium Vendor Registration Service: $25 Annual Registration Fee plus the appropriate order Transaction Fee specified below. eVA Premium Vendor Registration Service includes all benefits of the eVA Basic Vendor Registration Service plus automatic email or fax notification of solicitations and amendments.

c. For orders issued prior to August 16, 2006, the Vendor Transaction Fee is 1%, capped at a maximum of $500 per order.

d. For orders issued August 16, 2006 and after, the Vendor Transaction Fee is:
   (i) DMBE-certified Small Businesses: 1%, capped at $500 per order.
   (ii) Businesses that are not DMBE-certified Small Businesses: 1%, capped at $1,500 per order.

10.22 Availability of Funds

It is understood and agreed between the parties herein that the agency shall be bound hereunder only to the extent of the funds available or which may hereafter become available for the purpose of this agreement.

XI. SPECIAL TERMS AND CONDITIONS

11.1 Access to Premises

The Contractor shall allow duly authorized agents or representatives of the State or Federal Government, during normal business hours, access to Contractor's and subcontractors' premises, to inspect, audit, monitor or otherwise evaluate the performance of the Contractor's and subcontractor's contractual activities and shall forthwith produce all records requested as part of such review or audit. In the event right of access is requested under this section, the Contractor and subcontractor shall, upon request, provide and make available staff to assist in the audit or inspection effort, and provide adequate space on the premises to reasonably accommodate the State or Federal personnel conducting the audit or inspection effort. All inspections or audits shall be conducted in a manner as will not unduly interfere with the performance of Contractor or subcontractor's activities. The Contractor shall be given thirty (30) calendar days to respond to any preliminary findings of an audit before the Department shall finalize its findings. All information so obtained will be accorded confidential treatment as provided under applicable law.

The Department, the Office of the Attorney General of the Commonwealth of Virginia, the federal Department of Health and Human Services, and/or their duly authorized representatives shall be allowed access to evaluate through inspection or other means, the quality, appropriateness, and timeliness of services performed under this Contract.

11.2 Access To and Retention of Records

In addition to the requirements outlined below, the Contractor must comply, and must require compliance by its subcontractors with the security and confidentiality of records standards.

11.2.1 Access to Records

The Department, the Centers for Medicare and Medicaid Services, State and Federal auditors, or any of their duly authorized representatives shall have access to any books, fee schedules, documents, papers, and records of the Contractor and any of its subcontractors.

The Department, the Centers for Medicare and Medicaid Services, State and Federal auditors, or any of their duly authorized representatives, shall be allowed to inspect, copy, and audit any of the above documents, including, medical and/or financial records of the Contractor and its subcontractors.

11.2.2 Retention of Records

The Contractor shall retain all records and reports relating to this Contract for a period of six (6) years after final payment is made under this Contract or in the event that this Contract is renewed six (6) years after the final payment. When an audit, litigation, or other action involving or requiring access to records is initiated prior to the end of said period, however, records shall be maintained for a period of six (6) years following resolution of such action or longer if such action is still ongoing. Copies on microfilm or other appropriate media of the documents contemplated herein may be substituted for the originals provided that the microfilming or other duplicating procedures are reliable and are supported by an effective retrieval system which meets legal requirements to support litigation, and to be admissible into evidence in any court of law.

11.3 Advertising

In the event a contract is awarded for services resulting from this proposal, no indication of such sales or services to DMAS will be used in product literature or advertising without prior written permission from DMAS. The Contractor shall not state in any of its advertising or product literature that the Commonwealth of Virginia or any Department or institution of the Commonwealth has purchased or uses its products or services without prior written permission from DMAS. DMAS must approve any advertising, marketing or press release connected with this contract.

11.4 Audit

The Contractor shall retain all books, records, and other documents relative to this contract for six (6) years after final payment, or longer if audited by the Commonwealth of Virginia, whichever is sooner. The Department, its authorized agents, and/or State auditors shall have full access to and the right to examine any of said materials during said period.

11.5 Termination

This Contract may be terminated in whole or in part:

a. By the Department, for convenience, with not less than ninety (90) days prior written notice, which notice shall specify the effective date of the termination,
b. By the Department, in whole or in part, if funding from Federal, State, or other sources is withdrawn, reduced, or limited;
c. By the Department if the Department determines that the instability of the Contractor's financial condition threatens delivery of services and continued performance of the Contractor's responsibilities; or
d. By the Department if the Department determines that the Contractor has failed to satisfactorily perform its contracted duties and responsibilities.
e. Failure of the Contractor to identify overpayments that exceed a minimum of twice the contract costs may result in termination of the contract.

The Contractor shall not terminate this contract in part.

Each of these conditions for contract termination is described in the following paragraphs.

11.5.1 Termination for Convenience

The Department may terminate this Contract with or without cause, upon (90) days prior written notice to the Contractor. In addition, the Department may terminate the contract by opting out of the renewal clause. Any contract cancellation notice shall not relieve the Contractor of the obligation to deliver and/or perform on all outstanding services issued prior to the effective date of cancellation.

11.5.2 Cancellation of Contract

The Department reserves the right to cancel and terminate any resulting contract, in part or in whole, without penalty, upon 90 days written notice to the Contractor. Any contract cancellation notice shall not relieve the Contractor of the obligation to deliver and/or perform on all outstanding services issued prior to the effective date of cancellation.

11.5.3 Termination for Unavailable Funds

The Contractor understands and agrees that the Department shall be bound only to the extent of the funds available or which may become available for the purpose of this resulting Contract. When the Department makes a written determination that funds are not adequately appropriated or otherwise unavailable to support continuance of performance of this Contract, the Department shall, in whole or in part, cancel or terminate this Contract.

The Department's payment of funds for purposes of this Contract is subject to and conditioned upon the availability of funds for such purposes, whether Federal and/or State funds. The Department may terminate this Contract upon written notice to the Contractor at any time prior to the completion of this Contract, if, in the sole opinion of the Department, funding becomes unavailable for these services or such funds are

restricted or reduced. In the event that funds are restricted or reduced, it is agreed by both parties that, at the sole discretion of the Department, this Contract may be amended. If the Contractor shall be unable or unwilling to provide covered services at reduced rates, the Contract shall be terminated.

No damages, losses, or expenses may be sought by the Contractor against the Department, if, in the sole determination of the Department, funds become unavailable before or after this Contract between the parties is executed. A determination by the Department that funds are not appropriated or are otherwise inadequate or unavailable to support the continuance of this Contract shall be final and conclusive.

11.5.4 Termination Because of Financial Instability

In the event the Contractor becomes financially unstable to the point of threatening the ability of the Department to obtain the services provided for under the Contract, ceases to conduct business in the normal course, makes a general assignment for the benefit of creditors, or suffers or permits the appointment of a receiver for its business or assets, the Department may, at its option, immediately terminate this Contract effective at the close of business on a date specified by the Department. In the event the Department elects to terminate the Contract under this provision, the Contractor shall be notified in writing, by either certified or registered mail, specifying the date of termination. The Contractor shall submit a written waiver of the licensee's rights under the Federal bankruptcy laws.

In the event of the filing of a petition in bankruptcy by a principal network provider or subcontractor, the Contractor shall immediately so advise the Department. The Contractor shall ensure that all tasks that have been delegated to its subcontractor(s) are performed in accordance with the terms of this Contract.

11.5.5 Termination for Default

The Department may terminate the Contract, in whole or in part, if the Department determines that the Contractor has failed to satisfactorily perform its duties and responsibilities under this Contract and is unable to cure such failure within a reasonable period of time as specified in writing by the Department, taking into consideration the gravity and nature of the default. Such termination shall be referred to herein as "Termination for Default."

Upon determination by the Department that the Contractor has failed to satisfactorily perform its duties and responsibilities under this Contract, the Contractor shall be notified in writing, by either certified or registered mail, of the failure and of the time period which has been established to cure such failure. If the Contractor is unable to cure the failure within the specified time period, the Department will notify the Contractor in writing within thirty (30) calendar days of the last day of the specified time period that the Contract, has been terminated in full or in part, for default. This written notice will identify all of the Contractor's responsibilities in the case of the termination, including

responsibilities related to enrollee notification, network provider notification, refunds of advance payments, return or destruction of Department data and liability for medical claims.

In the event that DMAS determines that the Contractor's failure to perform its duties and responsibilities under this contract results in a substantial risk to the health and safety of Medicaid or FAMIS enrollees, DMAS may terminate this contract immediately without notice.
If, after notice of termination for default, it is determined by the Department or by a court of law that the Contractor was not in default or that the Contractor's failure to perform or make progress in performance was due to causes beyond the control of and without error or negligence on the part of the Contractor or any of its subcontractors, the notice of termination shall be deemed to have been issued as a termination for the convenience of the Department, and the rights and obligations of the parties shall be governed accordingly.

In the event of termination for default, in full or in part, as provided for under this clause, the Department may procure from other sources, upon such terms and in such manner as is deemed appropriate by the Department, supplies or services similar to those terminated, and the Contractor shall be liable for any costs for such similar supplies and services and all other damages allowed by law. In addition, the Contractor shall be liable to the Department for administrative costs incurred to procure such similar supplies or services as are needed to continue operations. In the event of a termination for default prior to the start of operations, any claim the Contractor may assert shall be governed by the procedures defined by the Department for handling contract termination. Nothing herein shall be construed as limiting any other remedies that may be available to the Department.

In the event of a termination for default during ongoing operations, the Contractor shall be paid for any outstanding payments due less any assessed damages.

11.6 Remedies for Violation, Breach, or Non-Performance of Contract

Upon receipt by the Department of evidence of substantial non-compliance by the Contractor with any of the provisions of this Contract or with State or federal laws or regulations the following remedies may be imposed.

11.6.1 Procedure for Contractor Noncompliance Notification

In the event that the Department identifies or learns of noncompliance with the terms of this contract, the Department will notify the Contractor in writing of the nature of the noncompliance. The Contractor must remedy the noncompliance within a time period established by the Department and the Department will designate a period of time, not less than ten (10) calendar days, in which the Contractor must provide a written response to the notification. The Department may develop or may require the Contractor

to develop procedures with which the Contractor must comply to eliminate or prevent the imposition of specific remedies.

11.6.2 Remedies Available to the Department

The Department reserves the right to employ, at the Department's sole discretion, any and all remedies available at law or equity including but not limited to, payment withholds and/or termination of the contract.

11.7 Performance Bonds

The Contractor shall deliver to the DMAS purchasing office an executed performance bond, in a form acceptable to DMAS, in the amount of one month of the estimated annual contract amount, with DMAS as obligee. The surety shall be a surety company or companies approved by the State Corporation Commission to transact business in the Commonwealth of Virginia. No payment shall be due and payable to the Contractor, even if the contract has been performed in whole or in part, until the bonds have been delivered to and approved by DMAS.

11.8 Payment

The Contractor shall be prepared to provide the full range of services requested under this RFP and resultant contract, on site and operationally ready to begin work by the implementation date established by DMAS. DMAS will provide adequate prior notice of at least 30 days of the implementation date. Upon approval of the Contractor's operational readiness and a determined start date, DMAS shall make payments as described in Section 10.

Each invoice submitted by the Contractor shall be subject to DMAS' approval based on satisfactory performance of contracted services and compliance with all contract terms. The invoice shall contain the federal tax identification number, the contract number and any other information subsequently required by DMAS.

Identification of Proposal Envelope

If a special envelope is not furnished, or if return in the special envelope is not possible, the signed bid/proposal should be returned in a separate envelope or package, sealed and identified as follows:

From:

Name of Offeror — Due Date /Time

Street or Box Number — City, State, Zip Code

_____
RFP Number

Name of Contract/Purchase Officer:

The envelope should be addressed as directed on Page 1 of the solicitation.

If a proposal not contained in the special envelope is mailed, the Offeror takes the risk that the envelope, even if marked as described above, may be inadvertently opened and the information compromised which may cause the proposal to be disqualified. Proposals may be hand delivered to the designated location in the office issuing the solicitation. No other correspondence or other proposals should be placed in the envelope.

11.10 Indemnification

Contractor agrees to indemnify, defend and hold harmless the Commonwealth of Virginia, its officers, agents, and employees from any claims, damages and actions of any kind or nature, whether at law or in equity, arising from or caused by the use of any materials, goods, or equipment of any kind or nature furnished by the Contractor/any services of any kind or nature furnished by the Contractor, provided that such liability is not attributable to the sole negligence of the using Department or to failure of the using Department to use the materials, goods, or equipment in the manner already and permanently described by the Contractor on the materials, goods or equipment delivered.

11.11 Small Businesses Subcontracting and Evidence of Compliance

A. It is the goal of the Commonwealth that 40% of its purchases be made from small businesses. This includes discretionary spending in prime contracts and subcontracts. All potential offerors are required to submit a Small Business Subcontracting Plan (Attachment C). Unless the offeror is registered as a DMBE-certified small business and where it is practicable for any portion of the awarded contract to be subcontracted to other suppliers, the contractor is encouraged to offer such subcontracting opportunities to DMBE-certified small businesses. This shall not exclude DMBE-certified women-owned and minority-owned businesses when they have received DMBE small business certification. No offeror or subcontractor shall be considered a Small Business, a Women-Owned Business or a Minority-Owned Business unless certified as such by the Department of Minority Business Enterprise (DMBE) by the due date for receipt of proposals. If small business subcontractors are used, the prime contractor agrees to report the use of small business subcontractors by providing the purchasing office at a minimum the following information: name of small business with the DMBE certification number, phone number, total dollar amount subcontracted, category type (small, women-owned, or minority-owned), and type of product/service provided.

B. Each prime contractor who wins an award in which provision of a small business subcontracting plan is a condition of the award, shall deliver to the contracting agency or institution on a quarterly basis, evidence of compliance (subject only to insubstantial shortfalls and to shortfalls arising from subcontractor default) with the small business subcontracting plan. When such business has been subcontracted to these firms and upon completion of the contract, the contractor agrees to furnish the purchasing office at a minimum the following information: name of firm with the DMBE certification number, phone number, total dollar amount subcontracted, category type (small, women-owned, or minority-owned), and type of product or service provided. Payment(s) may be withheld until compliance with the plan is received and confirmed by the agency or institution. The agency or institution reserves the right to pursue other appropriate remedies to include, but not be limited to, termination for default.

C. Each prime contractor who wins an award valued over $200,000 shall deliver to the contracting agency or institution on a quarterly basis, information on use of subcontractors that are not DMBE-certified small businesses. When such business has been subcontracted to these firms and upon completion of the contract, the contractor agrees to furnish the purchasing office at a minimum the following information: name of firm, phone number, total dollar amount subcontracted, and type of product or service provided.

11.12 Prime Contractor Responsibilities

The Contractor shall be responsible for completely supervising and directing the work under this contract and all subcontractors that it may utilize, using its best skill and attention. Subcontractors who perform work under this contract shall be responsible to the prime Contractor. The Contractor agrees that it is as fully responsible for the acts and omissions of its subcontractors and of persons employed by it as it is for the acts and omissions of its own employees.

11.13 Renewal of Contract

This contract may be renewed by the Commonwealth upon written agreement of both parties for three successive one-year periods, under the terms of the current contract, and at a reasonable time (approximately 90 days) prior to the expiration.

11.14 Confidentiality of Information

By submitting a proposal, the Contractor agrees that information or data obtained by the Contractor from DMAS during the course of determining and/or preparing a response to this RFP may not be used for any other purpose than determining and/or preparing the Contractor’s response. Such information or data may not be disseminated or discussed

for any reasons not directly related to the determination or preparation of the Contractor's response to this RFP.

11.15 HIPAA Compliance

The Contractor shall comply, and shall ensure that any and all subcontractors comply, with all state and federal laws and regulations with regards to handling, processing, or using Health Care Data. This includes but is not limited to the HIPAA regulations as it pertains to this agreement, and the Contractor shall keep abreast of the regulations. Since this is a federal law and the regulations apply to all health care information, the Contractor shall comply with the HIPAA regulations at no additional cost to DMAS. The Contractor shall also be required to enter into a DMAS-supplied HIPAA Business Associate Agreement with DMAS to comply with the regulations protecting Health Care Data. A template of this agreement is available on the DMAS' Internet Site at http://www.dmas.virginia.gov/hpa-home.htm.

11.16 Obligation of Contractor

By submitting a proposal, the Contractor covenants and agrees that it has satisfied itself of the conditions to be met, and fully understands its obligations, and that it will have no right to cancel its proposal or to relief of any other nature because of its misunderstanding or lack of information.

11.17 Independent Contractor

Any Contractor awarded a contract under this RFP shall be considered an independent Contractor, and neither the Contractor, nor personnel employed by the Contractor, is to be considered an employee or agent of DMAS.

11.18 Ownership of Intellectual Property

All copyright and patent rights to all papers, reports, forms, materials, creations, or inventions created or developed in the performance specific to this contract shall become the sole property of the Commonwealth. On request, the Contractor shall promptly provide an acknowledgement or assignment in a tangible form satisfactory to the Commonwealth to evidence the Commonwealth's sole ownership of specifically identified intellectual property created or developed in the performance of the contract.

11.19 Subsidiary-Parent Relationship

In the event the Offeror is a subsidiary or division of a parent organization, the Offeror must include in the proposal, a signed Statement by the chief executive officer of the parent organization pledging the full resources of the parent organization to meet the responsibilities of the subsidiary organization under contract to DMAS. DMAS must be notified within 10 days of any change in ownership. Any change in ownership shall not relieve the original parent of its obligation of pledging its full resources to meet the

obligations of the contract with DMAS without the expressed written consent of the DMAS' Director.

11.20 eVA Business-To-Government Contracts and Orders:

The solicitation/contract will result in 1 purchase order(s) with the eVA transaction fee specified below assessed for each order.

a. For orders issued prior to August 16, 2006, the Vendor Transaction Fee is 1%, capped at a maximum of $500 per order.

b. For orders issued August 16, 2006 and after, the Vendor Transaction Fee is:
(i) DMBE-certified Small Businesses: 1%, Capped at $500 per order.
(ii) Businesses that are not DMBE-certified Small Businesses: 1%, Capped at $1,500 per order.

The eVA transaction fee will be assessed approximately 30 days after each purchase order is issued. Any adjustments (increases/decreases) will be handled through eVA change orders.

Internet electronic procurement solution, website portal www.eva.State.va.us, streamlines and automates government purchasing activities in the Commonwealth. The portal is the gateway for vendors to conduct business with State agencies and public bodies.

Vendors desiring to provide goods and/or services to the Commonwealth shall participate in the eVA Internet e-Procurement Solution and agree to comply with the following:

If this solicitation is for a term contract, failure to provide an electronic catalog (price list) or index page catalog for items awarded will be just cause for the Commonwealth to reject your bid/offer or terminate this contract for default. The format of this electronic catalog shall conform to the eVA Catalog Interchange Format (CIF) Specification that can be accessed and downloaded from www.eVA.virginia.gov. Contractors should email Catalog or Index Page information to eVA-catalog-manager@dgs.virginia.gov.

11.21 Compliance with Virginia Information Technology Accessibility Standard

The Contractor shall comply with all State laws and regulations with regards to accessibility to information technology equipment, software, networks, and web sites used by blind and visually impaired individuals. This accessibility standards are State law see § 2.2-3502 and § 2.2-3503 of the Code of Virginia. Since this is a State law and the regulations apply to accessibility to information technology equipment, software, networks, and web sites used by blind and visually impaired individuals, the Contractor shall comply with the Virginia Information Technology Accessibility Standards at no additional cost to DMAS. The Contractor must also keep abreast of any future changes

to the Virginia Code as well as any subsequent revisions to the Virginia Information Technology Standards. The current Virginia Information Technology Accessibility Standards are published on the Internet at http://www.vita.virginia.gov/docs/websiteStandards.cfm

ATTACHMENT A

Managed Care Coverage and Characteristics Map

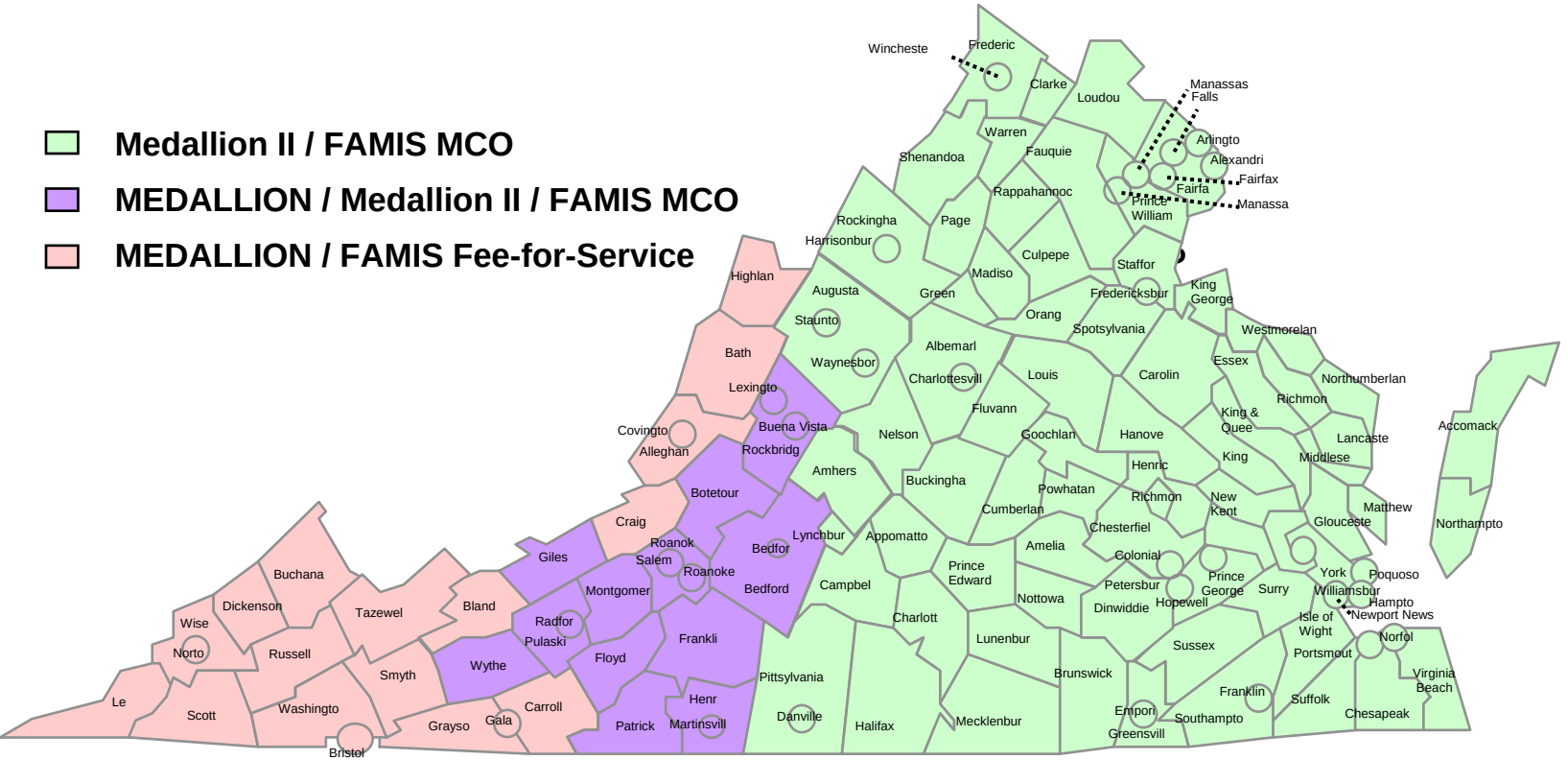
Managed Care Coverage Map and MCO Characteristics

Health Plans	Enrollees as of February 2008*	Localities and Medallion II Start Date
AMERIGROUP Community Care 4425 Corporation Lane Virginia Beach, VA 23462	23,997	11 cities/counties Northern Virginia Start Date: 09/01/2005
Anthem HealthKeepers Plus 2220 Edward Holland Drive Richmond, VA 23230	158,491	81 cities /counties Tidewater, Central Virginia, Halifax , Winchester, Northern Virginia and Charlottesville Regions Start Date: 01/01/1996
Care*N*et / Southern Health Services 9881 Mayland Drive Richmond, VA 23233	18,843	30 cities/counties Tidewater, Central Virginia and Lynchburg Regions Start Date: 04/01/1996
Optima Family Care 4417 Corporation Lane Virginia Beach, Virginia 23462	130,304	76 cities/counties Tidewater, Central Virginia, Charlottesville, Halifax, Winchester and Lynchburg Regions Start Date: 01/01/1996
Virginia Premier Health Plan 600 E. Broad Street, Suite 400 Richmond, VA 23219-1800	124,789	87 cities/counties Tidewater, Central Virginia, Charlottesville, Roanoke Winchester and Lynchburg Regions Start Date: 01/01/1996

*Enrollment counts include Medallion II and FAMIS
Updated: 03/06/2008

Virginia Medicaid Managed Care Program Coverage Map

February 2008



Enrollment Report
March 2008

Enrollments - This Month

FFS*			MEDALLION*			Medallion II*			**Total**
245,700			51,366			410,248			**707,314**
35%			7%			58%			**100%**
FFS	AC 094	FAMIS Plus	MEDALLION	AC 094	FAMIS Plus	Medallion II	AC 094	FAMIS Plus	
183,589	4,750	57,361	18,921	3,442	29,003	109,034	28,613	272,601	
75%	2%	23%	37%	7%	56%	27%	7%	66%	

FAMIS Enrollment Report
March 2008

Enrollments - This Month

FAMIS FFS*			FAMIS PCCM*			FAMIS MCO*			Total
7,368			1,084			44,716			53,168
14%			2%			84%			100%
FAMIS FFS		FAMIS Moms	FAMIS PCCM		FAMIS Moms	FAMIS MCO		FAMIS Moms	
7,145		223	1,084		-	43,826		890	
97%		3%	100%		0%	98%		2%	

ATTACHMENT C

Small, Women and Minority-Owned Businesses Utilization Plan

Attachment C:
Small Business Enterprise Utilization Plan

Offeror Name: _____

Preparer Name: _____ Date: _____

Is your firm a Small Business Enterprise certified by the Department of Minority Business Enterprise? Yes_____ No_____
If yes, certification number: _____ Certification date:_____

Is your firm a Woman-owned Business Enterprise certified by the Department of Minority Business Enterprise? Yes_____ No_____
If yes, certification number: _____ Certification date:_____

Is your firm a Minority-Owned Business Enterprise certified by the Department of Minority Business Enterprise? Yes____ No_____
If yes, certification number: _____ Certification date:_____

Instructions: Populate the table below to show your firm's plans for utilization of small, women-owned and minority-owned business enterprises in the performance of the Collection Services contract. Describe plans to utilize SWAMs businesses as part of joint ventures, partnerships, subcontractors, suppliers, etc.

Small Business Enterprise: "Small business enterprise" shall mean an independently owned and operated business which, together with affiliates, has 250 or fewer employees or average annual gross receipts of $10 million or less averaged over the previous three years. Nothing in this provision prevents a program, agency, institution or subdivision from complying with the qualification criteria of a specific state program or a federal guideline to be in compliance with a federal grant or program. For purposes of the SWAM Program, the definition of small business enterprise shall be interpreted to include all certified women-owned and minority-owned businesses.

Woman-Owned Business Enterprise: A business concern which is at least 51 percent owned by one or more women who are U.S. citizens or legal resident aliens, or in the case of a corporation, partnership or limited liability company or other entity, at least 51 percent of the equity ownership interest in which is owned by one or more women, and whose management and daily business operations are controlled by one or more of such individuals. For purposes of the SWAM

Program, all certified women-owned businesses are also a small business enterprise.
Minority-Owned Business Enterprise: A business concern which is at least 51 percent owned by one or more minorities or in the case of a corporation, partnership or limited liability company or other entity, at least 51 percent of the equity ownership interest in which is owned by one or more minorities and whose management and daily business operations are controlled by one or more of such individuals. For purposes of the

SWAM Program, all certified minority-owned businesses are also a small business enterprise.

All small, women, and minority owned businesses must be certified by the Commonwealth of Virginia Department of Minority Business Enterprise (DMBE) to be counted in the SWAM program. Certification applications are available through DMBE at 800-223-0671 in Virginia, 804-786-6585 outside Virginia, or online at www.dmbe.virginia.gov (Customer Service).

1. Plans for utilization of SWAM Businesses					
SWAM Business Name & Address	SWAM Status: Small (S), Women (W), Minority (M) & DMBE Certif. # & Date	Contact Person, Tele. & Email	Type of Goods and/or Services	Planned Contract Involvement	Planned Annual Contract Dollar Expenditure Amount
Totals $					

ATTACHMENT D

Cost Proposal

Fiscal Year 1 Deliverable Matrix – Due Dates and Costs for Tasks and Deliverables

For each task, delineate as follows: Number, type and estimated percent of each FTE for each task per year with total cost for combined FTEs for each task; travel costs; indirect costs for facility and staff operations; survey costs; use of advanced technology (web-based teaching, etc.); retrieval of medical records and their abstraction (if separate from FTEs); printing costs; other. If the Offeror does not anticipate any costs associated with a particular task during this fiscal year, indicate this by a "not applicable" in the cost column. The Offeror should be mindful that although a particular task may not be completed in a particular year, there may be preparation work that should be done in an earlier year.

Task	**Deliverables** **FY 2009: November 1, 2008 – October 31, 2009**	**Cost Per Task Per Fiscal Year**
R- A	• Entrance conference • Annual work plan(s)	
R- B	• Operations preparedness plan • Disaster recovery plan	
O- C	• Provision for quality improvement education and communications	
O- D	• Quarterly collaborative meetings, beginning with March 2009 • Collaborative tool kit	
R- E	PIPs validation reports	
R- F	Required focused studies (delineate costs per study per year)	
O-G	Optional focused studies	
R- H	MCO performance measure validation	
R- I	Dental review	
R- J	Transportation review	
R- K	MCO modified operational systems review	
R- L	VALTC needs assessment	
R- N	Consumer satisfaction surveys	
R- O	PACE site compliance review	
R- P	Independent Review of FAMIS Appeals	
	TOTAL Fiscal Year 1	**Total Required Tasks:** **Total Optional Tasks:** **Total all Tasks:**

Fiscal Year 2 Deliverable Matrix – Due Dates and Costs for Tasks and Deliverables

For each task, delineate as follows: Number, type and estimated percent of each FTE for each task per year with total cost for combined FTEs for each task; travel costs; indirect costs for facility and staff operations; survey costs; use of advanced technology (web-based teaching, etc.); retrieval of medical records and their abstraction (if separate from FTEs); printing costs; other. If the Offeror does not anticipate any costs associated with a particular task during this fiscal year, indicate this by a "not applicable" in the cost column. The Offeror should be mindful that although a particular task may not be completed in a particular year, there may be preparation work that should be done in an earlier year.

Task	**Deliverables** **FY 2009: November 1, 2009 – October 31, 2010**	**Cost Per Task Per Fiscal Year**
R- A	• Entrance conference • Annual work plan(s)	
R- B	• Operations preparedness plan • Disaster recovery plan	
O- C	• Provision for quality improvement education and communications	
O- D	• Quarterly collaborative meetings, beginning with March 2009 • Collaborative tool kit	
R- E	PIPs validation reports	
R- F	Required focused studies (delineate costs per study per year)	
O-G	Optional focused studies	
R- H	MCO performance measure validation	
R- I	Dental review	
R- J	Transportation review	
R- K	MCO modified operational systems review	
R- L	VALTC needs assessment	
R- N	Consumer satisfaction surveys	
R- O	PACE site compliance review	
R- P	Independent Review of FAMIS Appeals	
	TOTAL Fiscal Year 2	**Total Required Tasks:** **Total Optional Tasks:** **Total all Tasks:**

Fiscal Year 3 Deliverable Matrix – Due Dates and Costs for Tasks and Deliverables

For each task, delineate as follows: Number, type and estimated percent of each FTE for each task per year with total cost for combined FTEs for each task; travel costs; indirect costs for facility and staff operations; survey costs; use of advanced technology (web-based teaching, etc.); retrieval of medical records and their abstraction (if separate from FTEs); printing costs; other. If the Offeror does not anticipate any costs associated with a particular task during this fiscal year, indicate this by a "not applicable" in the cost column. The Offeror should be mindful that although a particular task may not be completed in a particular year, there may be preparation work that should be done in an earlier year.

Task	**Deliverables** **FY 2009: November 1, 2010 – October 31, 2011**	**Cost Per Task Per Fiscal Year**
R- A	• Entrance conference • Annual work plan(s)	
R- B	• Operations preparedness plan • Disaster recovery plan	
O- C	• Provision for quality improvement education and communications	
O- D	• Quarterly collaborative meetings, beginning with March 2009 • Collaborative tool kit	
R- E	PIPs validation reports	
R- F	Required focused studies (delineate costs per study per year)	
O-G	Optional focused studies	
R- H	MCO performance measure validation	
R- I	Dental review	
R- J	Transportation review	
R- K	MCO comprehensive operational systems review	
R- L	VALTC needs assessment	
R- N	Consumer satisfaction surveys	
R- O	PACE site compliance review	
R- P	Independent Review of FAMIS Appeals	
	TOTAL Fiscal Year 3	**Total Required Tasks:** **Total Optional Tasks:** **Total all Tasks:**

Compensation under the contract will be paid in accordance with the RFP requirements or 1/12 of the respective fiscal year's total amount for all deliverables. Upon completion of each deliverable, to the satisfaction of DMAS, the Contractor may invoice DMAS for the balance of the completed task. All monthly invoices must include the contract number, the Contractor FIN number and the activity for the month. *No system change will be reimbursed by DMAS unless the programming for such change is in excess of 40 hours per project.

Note: General and Administrative and other indirect costs must be included in the direct cost figures. (DMAS will not consider G&A or other fees as a separate line item.)

ATTACHMENT E

Reference Form

Reference Form:

Contract Name:	
Customer name and address:	
Customer contact and title:	
Contact Phone number:	
Scope of Services of Contract:	
Contract Type (fixed price, fee for service, capitation, etc)	
Contract Size (# of clients served, number of trips, etc):	
Contract Period	
Number of Contractor staff assigned to contract:	
Annual Value of Contract:	

ATTACHMENT F

PACE site assessment

CMS HPMS Database
Participant Data Collected

Requirements	Data Collection	Definition
1. Routine immunizations	a. What will be reported: 1. Number of participants who received the flu immunization this year; 2. Number of participants who have received the pneumococcal immunization in the last 10 years; 3. Total number of participants at the PACE organization; 4. Number of participants not immunized for flu; and number of participants not immunized for pneumococcal; 5. Reason for not immunizing. b. Frequency: During the inoculation time period (e.g. Sept. to Jan.) c. How to measure: Compare the number of PACE participants who were enrolled during the reporting year to the number of participants who received routine immunizations (flu and pneumococcal) during the reporting year. Minimum levels of performance: the organization will achieve an immunization rate for both influenza and pneumococcal vaccinations of 80% for the participant population that is appropriate. (Rate will exclude those participants who have had prior immunization or the vaccine is medically contraindicated).	PACE participants who received routine immunizations during the reporting year.
Requirements	**Data Collection**	**Definition**
2. Grievance and appeals	a. What data will be reported: 1. Total number of participants during the	Grievances are defined as either a written or oral complaints that

	quarter; 2. Total number of grievances filed during the quarter; 3. Total number of appeals filed during the quarter; 4. Source of each grievance or appeal; and 5. Date of initiation of each grievance or appeal; and 6. Date of resolution of each grievance or appeal. b. Frequency: quarterly c. How do you measure: Monitor trends and patterns. The actual number of grievances and appeals alone should not be viewed as an indicator of a problem. The high number of grievances could mean that participants are encouraged to speak up for themselves and voice their concerns.	expresses dissatisfaction with service delivery or the quality of care provided. Appeals are defined as a written complaint for the noncoverage or nonpayment of a service or item.
3. Enrollments	a. What data will be reported: 1. Number of individuals who enrolled in the program; b. Frequency: quarterly c. How to use the measure: Monitor trends and patterns to determine if there are any accessibility issues and to determine if the PACE organization has a sufficient financial resource to conduct appropriate marketing activities. This information can also be used to evaluate the PACE organization's ability to maintain an appropriate census.	Individuals enrolled in the PACE program by month.

Requirements	Data Collection	Definition
4. Disenrollments	a. What data will be reported: 1. Total number of participants; 2. Number of voluntary disenrollments; 3. Number of involuntary disenrollments; and 4. Reason for each disenrollment: leaving the service area, failure to pay premium, disruptive or threatening behavior, no longer meets States level of care, program agreement with CMS terminates or not renewed, organization is unable to offer services due to loss of State license, keep personal physician, wishes to access out of network or other. b. Frequency: quarterly c. How to use the measure: Utilize this information to determine if there are any problems with site operations, such as accessibility, provision of services, etc. that are causing voluntary disenrollments. In addition, this information can be used to review the organization's policies on involuntary disenrollments.	Participants who disenrolled from the program for reasons other than death.
5. Prospective Enrollees (participants)	a. What data will be reported: 1. Number of potential participants who were interviewed but did not enroll in the PACE program by aggregate reason; and 2. Indicate the category that explains the reason each potential participant did not enroll, e.g. not safe to remain in the community, mental health concerns, lack of support network, requiring 24-hour care, preference for own physician, preference for	Potential participants who were interviewed, met eligibility requirements but did not enroll in the PACE program.

	other health care provider of institution, financial reason to avoid share of cost, unwilling to comply with treatment plan, or other with explanation. b. Frequency: quarterly c. How to use the measure: This information can be utilized to determine if the PACE organization is following the appropriate eligibility criteria and to determine if the organization is conducting appropriate marketing activities.	
6. Readmissions	a. What data will be reported: 1. Total number of participants; 2. Total number of participants admitted to the hospital in the last 30 days; 3. Specific reason, including diagnosis, for participant's admission. b. Frequency: quarterly c. How to use the measure: Review those with high usage to determine if intervention by the PACE organization could have prevented some of the hospitalizations. Readmission for the same reason in a 30 day period could indicate that the length of stay is too short or there is inadequate follow-up care by the PACE organization. Conduct quarterly comparisons to get a total picture of the care provided by the organization.	PACE participants re-admitted to an acute care hospital (excluding hospitalizations for diagnostic tests) in the last 30 days.

Requirements	Data Collection	Definition
7. Emergent care	a. What data will be reported: 1. Total number of participants; 2. Total number of participants by (aggregate) same diagnosis; and, 3. Specific reason including diagnosis. b. Frequency: quarterly c. How to use the measure: Review those with high usuage to determine if intervention by the PACE organization could have prevented some of the visits to the ER.	PACE participants seen in the hospital emergency room (including care from a PACE physician in a hospital emergency department) or an outpatient department/clinic emergency, or surgical center.
8. Unusual incidents for participants and the PACE site (to include staff if participant was involved)	a. Number of unusual incidents aggregated by reason. b. Frequency: quarterly c. How to use the measure: Analyze categories focusing on whether these incidents were preventable, what steps were taken to resolve the problem, and what changes are being made to improve prevention. Is there a pattern that indicates a need for follow-up to investigate health and safety issues and procedures? Is this a program problem (e.g. negligence by staff) or a participant problem (e.g. verbal outbursts by participant with mental illness or severe dementia?	Unanticipated circumstances, occurrences or situations which have the potential for serious consequences for the participants. Examples include, but are not limited to: falls at home or the adult day health center, falls while getting into the van, van accidents other than falls; participant suicide or attempted suicide; staff criminal records; infectious or communicable disease outbreaks; food poisoning; fire or other disasters; participant injury that required follow-up medical treatment; participant injury on equipment; lawsuits; medication errors and nay type of restraint use. This is not an inclusive list, so we would expect PACE sites to submit quarterly information on any unanticipated situations that occur.

Requirements	Data Collection	Definition
9. Deaths	a. What data will be reported: 1. Number of participants (can be aggregated by reason and setting, if same); 2. Number of deaths; 3. Setting of the participant's death; and, 4. Cause of the participant's death. b. Frequency: quarterly c. How to use the measure: Analysis to determine if there is a pattern indicating inappropriate setting for the participant or problems with accessibility to 24 hour care. Because of the link between the number of deaths and enrollment, this information may also indicate if the PACE organization is maintaining an appropriate census to remain fiscally viable.	Death of participants during the given reporting period.

*** The data submitted must come exclusively from the PACE organization, not the parent organization. If the PACE organization has more than one site of care/treatment, each site must be indentified separately.